VOL. XXXIV, NO. 8 AUGUST, 1916 WHOLE NO. 407

DUPLICATE

LIBRARY
APR 2 1946
UNIVERSITY OF TORONTO

The Journal of Cutaneous Diseases

Including Syphilis

RL
1
J6
V.34
no.8

Biological
& Medical
Serials

OFFICIAL ORGAN OF THE
AMERICAN DERMATOLOGICAL ASSOCIATION

$5.00 A YEAR IN ADVANCE

GEORGE M. MACKEE, M.D., New York, Editor
FRED WISE, M.D., New York, Associate Editor

BOSTON, MASS.
W. M. LEONARD, PUBLISHER
1916

FELLOWS' Compound Syrup of Hypophosphites

1866—1916

Not a new-born prodigy or an untried experiment, but a remedy whose usefulness has been fully demonstrated during half a century of clinical application.

For 50 Years The Standard

℞ Syr. Hypophos. Comp. FELLOWS'

Reject < Cheap and Inefficient Substitutes
Preparations "Just as Good"

THE FELLOWS
MEDICAL MANFG. CO. LTD.
26 CHRISTOPHER ST.
NEW YORK

EQUIPMENT

for **Serum Therapy**

Serums and Sero-Bacterins

for **Heliotherapy**

Lamps and Appliances

Surgical Instruments

Surgical Supplies

WE FILL FOR PHYSICIANS EVERY REQUIREMENT
FOR OFFICE AND CLINICAL WORK

Send us your Inquiry. Let us send information of latest progress in every branch of Appliances for Practitioners

---

The F. H. Thomas Co.

BOSTON

THE JOURNAL OF CUTANEOUS DISEASES INCLUDING SYPHILIS

Published Monthly by W. M. LEONARD, 101 Tremont Street, Boston, Mass.

To whom all business communications should be addressed

Entered as second-class matter at the Post Office at Boston, Mass.

OWNED BY AND PUBLISHED UNDER THE AUSPICES OF THE AMERICAN DERMATOLOGICAL ASSOCIATION

OFFICERS, 1916–1917

A. Ravogli, M.D., *President.*

Ernest E. McEwen, M.D., *Vice-President.*

Oliver S. Ormsby, M.D.
25 East Washington St., Chicago, Ill., *Secretary-Treasurer.*

COUNCIL

A. Ravogli, M.D. — Howard Fox, M.D.

Charles J. White, M.D. — Oliver S. Ormsby, M.D.

Communications relating to the editorial department may be addressed to George M. MacKee, M.D., Editor, 58 West 58th Street, New York

CONTENTS FOR AUGUST, 1916

ORIGINAL COMMUNICATIONS

The Dermatologist, the Proper Teacher of Syphilis. Joseph Zeisler, M.D... 583
Congenital and Bone Syphilis. Abner Post, M.D..... 589
Pastes. Douglass W. Montgomery, M.D..... 596
Nævus Anæmicus. John E. Lane, M.D..... 602

CLINICAL REPORT

Argyria From an Unusual Source. A. Davidson, M.D..... 605

CORRESPONDENCE

Treatment of Tinea Barbae. W. M. Beck, M.D..... 606

SOCIETY TRANSACTIONS

New York Dermatological Society, Feb. 15, 1916..... 607
Chicago Dermatological Society, Dec. 21, 1915..... 613
Manhattan Dermatological Society, Jan. 14, 1916..... 617
Minnesota Dermatological Society, Apr. 11, 1916..... 620

REVIEW OF DERMATOLOGY AND SYPHILIS

Dermatologische Wochenschrift.....Max Scheer, M.D. 623
Annales des maladies vénériennes.....Paul E. Bechet, M.D., 624
Russki Joornal Kojnikh E Venericheskikh Boleznei.....M. L. Ravitch, M.D. 626
British Journal of Dermatology.....I. Rosen, M.D. 628
Journal of Experimental Medicine.....R. C. Jamieson, M.D. 630
Annales De l'Institute Pasteur..... " " " " 632
American Journal of the Medical Sciences..... " " " " 632

NOTICES

Arsenobenzol 632
Salvarsan 632
News Items 632

Which Mineral Oil is Best for Medical and Surgical Use

?

1. That oil which is free from paraffin and all toxic, irritating or otherwise undesirable elements, such as anthracene, phenanthrene, chrysene, phenols, oxidized acid and basic bodies, organic sulphur compounds and foreign inorganic matter; because an oil of such purity will pass through the gastro-intestinal tract without causing irritation or other untoward effects.

2. That oil which possesses the highest natural viscosity, with the highest specific gravity, because such an oil will pass through the intestine more slowly than a lighter and thinner oil and lubricate the walls of the gut more completely, and soften fæces more effectually, and is not likely to produce dribbling.

3. That oil which is really colorless, odorless and tasteless, because palatability favors persistence in treatment.

The oil which meets all these requirements is

Liquid Petrolatum, Squibb

Heavy (Californian)

It is a pure, colorless, odorless and tasteless **Mineral Oil,** specially refined under our control only by the *Standard Oil Company* of *California* which has no connection with any other Standard Oil Company. This oil has the very high specific gravity of 0.886 to 0.892 at 15°C. (or 0.881 to 0.887 at 25°C.) and has also an exceptionally high natural viscosity. It is sold solely under the Squibb label and guaranty and may be had at all leading drug stores.

E. R. SQUIBB & SONS, New York

Treat "PORT-WINE NEVUS," TELANGIECTASIS, ROSACEA, etc.

WITH THE

KROMAYER LAMP

SEE

"Therapeutic Gazette," May, 1915

Pages 312—317

HANOVIA

Chemical & Mfg. Co.

Newark, N. J.

New York Office

CHAS. ENGELHARD

30 Church St.

Have you a copy of this catalogue?

It is No. **J 60** free on request

Salvarsan 0.6 Gram and Neosalvarsan No. VI (0.9 Gram)

Ample quantities of these products have been received from Germany by permission of the German Government, upon the explicit orders of Kaiser Wilhelm, and on permits issued by the British and French Governments for safe passage.

We are now prepared to supply physicians and hospitals direct, at the price prevailing hitherto, of $4.50 per ampule, in such reasonable quantities as purchasers may desire for current use.

In view of the appearance on the market of substitutes of Salvarsan and Neosalvarsan, some of which infringe the Ehrlich patents, others exhibiting marked toxic properties, and still others being absolutely fraudulent and harmful, we desire to impress upon the medical profession that we are the sole importers of and agents for Salvarsan and Neosalvarsan in the United States. These products can only be produced from us at the present time. Direct distribution is carried out to prevent speculation on the part of unscrupulous persons or dealers and will be followed during the continuance of the war.

FARBWERKE-HOECHST COMPANY

H. A. METZ, President — Pharmaceutical Department

111-113 Hudson Street, NEW YORK CITY

The Journal of Cutaneous Diseases

INCLUDING SYPHILIS

THE JOURNAL, ever since its first issue, in 1884, has been the representative dermatological journal of America.

Through the high standing of its Editorial Directors and its invaluable scientific contents, THE JOURNAL has won well-deserved recognition throughout the world.

THE JOURNAL was purchased by the American Dermatological Association and passed into the control of this illustrious body with the birth of 1912.

When THE JOURNAL became the official organ of the American Dermatological Association it was enabled to offer its readers the complete yearly transactions of this body.

This required a great deal of space, and room was made for the many worthy independent contributions by increasing the size of THE JOURNAL from forty-eight to an average of sixty-eight pages, and now to 90 pages.

The character of the mechanical work on THE JOURNAL—printing, illustrations, stock, etc., is the best that can be attained.

A new feature that should be of great interest and value to our readers is the New Abstract Department. Every issue of every dermatological journal in the world, and all articles of interest to the dermatologist, appearing in general medical journals and journals of the various medical specialties, of all countries, will be carefully, completely and promptly abstracted. In addition, about every second or third issue will contain a special review of some important topic, as, for instance, salvarsan, sporotrichosis, radiotherapy, the Wassermann reaction, etc. Also each issue will contain special articles on histopathology, pathology, etc.

Now what does THE JOURNAL give its subscribers?

1. The complete transactions of the American Dermatological Association; New York Dermatological Society; Section on Dermatology of the New York Academy of Medicine; Manhattan Dermatological Society; Philadelphia Dermatological Society; Boston Dermatological Society; and Chicago Dermatological Society.

2. There are from three to six original contributions of the highest class in each issue.

3. The Review Department contains an abstract in English of every article of dermatological interest published in any country of the world. New publications are acknowledged at once and a review is published in from one to three months.

4. Ninety pages each month, forming a yearly volume of 1,080 pages of scientific material that is indispensable to the physician who is interested in dermatology, syphilology and radiotherapy.

All for the small amount of $5.00 per annum
Send your subscription now, lest you forget

W. M. Leonard, Publisher, Boston, Mass.

The Successful Care of the Hair and Scalp

Depends primarily on effective cleanliness of the scalp. To secure this, the medical profession have been using

PACKER'S TAR SOAP

for many years, and with such uniformly satisfactory results that it has become widely recognized as the standard shampooing agent.

Used at proper intervals with systematic thoroughness, this pure, pine-tar soap not only assures perfect scalp cleanliness, but in addition imparts a tonic stimulation to the scalp tissues that promptly manifests itself by a marked improvement in the vitality and lustre of the hair.

THE PACKER MFG. CO. **NEW YORK CITY**

Elixir Iodo-Bromide of Calcium Comp.

(TILDEN'S)

In addition to the Iodides of Potassium and Calcium, contains vegetable anti-syphilitics and alteratives most conspicuously and unanimously recognized by the best therapeutic authorities.

Free Samples to the Profession upon Application

The Tilden Company

Manufacturing Pharmacists and Chemists
Since 1848

New Lebanon, N. Y. **St. Louis, Mo.**

This is a CO_2 ICE CRAYON made in two minutes with a new GOOSMANN instrument. Used in the treatment of over forty different skin lesions. Price $15.00. Order through dealer or direct from

Alda Manufacturing Co.

223 W. Huron Street
Chicago

THE JOURNAL OF
CUTANEOUS DISEASES

VOL. XXXIV AUGUST, 1916 NO. 8

ORIGINAL COMMUNICATIONS.

THE DERMATOLOGIST, THE PROPER TEACHER OF SYPHILIS.*†

BY JOSEPH ZEISLER, M.D., CHICAGO.

THE wording of my address is not of my own choosing. I might have felt more like selecting, diplomatically, a less compromising title. But as it comes to me in the form of a mandate from the council of the American Dermatological Association, establishing the official attitude of this representative body, it behooves me to make my plea, to the best of my ability, as the spokesman of our organization, and I approach my task cheerfully and without any restraint, as I am fully and unhesitatingly in accord with the views implied in the title.

Why has it become necessary to discuss the question of who should teach the subject of syphilis in our medical schools? Has the derma-

* Read before the 40th Annual Meeting of the American Dermatological Association, Washington, D. C., May 8, 9, and 10, 1916.

† This article, together with papers by Drs. Post, Wile, Fordyce and Pollitzer, represent the symposium on syphilis delivered at the 40th Annual Meeting of the American Dermatological Association. Of the papers comprising the symposium those of Drs. Zeisler and Post are published in this issue. The remainder of the symposium, together with the discussion, will appear in the September issue.

tologist lost his ability or his right to appear in authoritative attitude towards it? Or has he lost his interest in it? Or has some other existing and recognized department of medicine developed more valid claims? Or has the time arrived when the subject of syphilis has assumed proportions so big and comprehensive as to justify its separation from all other established chairs, and its elevation to the dignity of a distinct and independent department of medicine with a correspondingly distinct and independent chair for its teaching? And granting, for the sake of argument, that this might be so, would such a radical departure be to the best interest of the student and the medical profession at large? Is the present or hitherto recognized or tolerated manner of teaching the subject entirely satisfactory and beyond the need of improvement, of modification? And finally, what should be the ideal, form, scope and extent of instruction?

All these questions are of paramount interest, and an unbiased answer to them should be forthcoming, not only from us as dermatologists, but after careful and thoughtful deliberation, from the responsible heads of our best medical schools.

The timeliness and acuteness of this discussion is evidenced by the positive stand taken already by one of the most prominent schools in this country in boldly separating the subject of syphilis from that of dermatology and assigning it to a newly created head.

That syphilis, during the last twelve years, by almost spectacular scientific advances has easily come to occupy the foreground of medical interest; that pathologic, experimental, biologic, therapeutic studies in relation to it have rushed into the columns of contemporary medical literature with torrential impetus, is, of course, a matter of record. In contrast to previous comparative stagnation, what a precipitate flow of epoch-making events! Like milestones, we distinguish: the successful inoculation of monkeys and other animals with syphilis, in 1903, by Metchnikoff and others; the discovery of the Spirochæte pallida, by Schaudinn and Hoffmann, in 1905; the serological diagnosis of lues by Wassermann, Neisser and Bruck, in 1906; the successful cultivation, in pure culture, of the spirochæte by Volpine and Fontana, in 1906, by Schereschewsky in 1909, later by Mühlens and Noguchi; the therapeutic experiments by Ehrlich, with their sensational climax—salvarsan, in 1910; the final establishment of the luetic nature of tabes and general paralysis through the demonstration of the culpable organism by Noguchi, in 1913.

The progress here outlined has had its far-reaching effect, not merely upon dermatology, but upon every single department of medicine. The

newly aroused and absorbing interest in the subject of syphilis was shared by general practitioner and specialist alike. But while we are far from overlooking the fact that much of the fundamental work referred to, was inaugurated by scientists outside of the department of dermatology, in fact outside of medicine in general, for Schaudinn was primarily a zoölogist, Metchnikoff a pure biologist, and Ehrlich chiefly a chemist, it is, nevertheless, but fair to admit that the overwhelming amount of clinical and laboratory work in confirmation and elaboration of that basic groundwork was done by dermato-syphilologists, as can be easily proven from the record of recent literature.

But it was unavoidable that the subject of syphilis, which was formerly considered a legitimate field of study and practice for the dermatologist, had now become, as it were, more accessible to the special workers in all other departments of medicine and to every general practitioner. No further need of the man specially trained in diagnosing the multiform and often doubtful and ambiguous manifestations of the disease, or in managing a case with judgment, experience, discrimination and technical skill. The matter had become so perfectly simple. Why worry whether an unfamiliar rash was a syphilitic roseola, or rather, a pityriasis rosea or toxic erythema? Whether a swelling on the leg was a gumma or an erythema induratum or nodosum? A tumor on the lip a chancre or an epithelioma? Who cared whether a chronic eruption was a psoriasis, a lichen planus or a papular syphilide? Why trouble whether an ulceration of the nose was of syphilitic, carcinomatous, or tuberculous nature? Or vegetations on the lip a pemphigus vegetans or condylomata lata? Even lepra or elephantiasis need not concern the self-satisfied, nonchalant practitioner. All these and hundreds of other diagnostic problems had become reduced to a simple, almost mathematical proposition. The laboratory, the reliable and infallible(!) Wassermann test, relieves him of all possible doubt and responsibility. And the treatment? Provided always, that the case is actually one of syphilis; again how simple! One or two "shots" of "606" and the work is accomplished.

But is the Wassermann test in reality all that is required for the diagnosis of a dubious case? With all due regard for its value as a confirmatory symptom, has not every one of us, time and again, known it to fail? How many tabetics give persistently a negative result! How often will different laboratories, supposedly trustworthy, report absolutely contradictory findings in the same patient! But this is not the place to enlarge upon this intricate matter.

And has salvarsan, with its substitutes, kept all the promises that

were held out for it when it first made its spectacular entry? The beautiful dream of the *sterilizatio magna*, like all dreams, did not last long. Soon enough, while fully appreciating its great merits, we learned to look upon it not as a sure curative agent, but as a most welcome, though by no means always indispensable, addition to our weapons against lues. The old and tried methods have not been entirely discarded, and he would indeed be a narrow practitioner who should be willing to ignore the accumulated therapeutic experiences of our teachers, who in their day—let us be fair—did not do so much worse than we can today. But here again I must avoid the temptation of going into detail. The fact remains that diagnosis and treatment of syphilis have not been simplified: they have become vastly more complicated. Instruction in them must be given by the man who has mastered the new accomplishments but has not forgotten the good old traditional treasures. These qualifications are found among the best dermatologists, rather than elsewhere. But the claims of the dermatologist upon the domain of syphilis are not only based on tradition. Everybody familiar with its literature knows that the foremost dermatologists of all times have been among the pathfinders, the teachers, the earnest workers in it. Have we forgotten Unna's and Auspitz's work on the primary lesion? Were Kaposi, Fournier, Leloir, Taylor, Hutchinson, Schwimmer, are Neisser, Hallopeau, Fordyce, and so many others less competent to teach syphilis because they were or are eminent dermatologists? Has their hold upon it loosened because representatives of other branches of medicine have lately crowded themselves forward? The genito-urinary surgeons (or are they now to be called urologists?) seem to encroach more and more upon our legitimate field. Upon what ground? Because the primary lesion of lues often occurs upon the outer genitalia! Theirs is a large and important field, requiring more than ordinary technical accomplishments, but it is distinctly a branch of surgery. Why they should consider themselves competent to decide fine points in differential diagnosis of cutaneous and mucous membrane lesions, a daily demand upon the syphilologist, is difficult to see. With equal right could the neurologist advance his claims, because tabes and general paralysis are the result of syphilis, or the ophthalmologist, because iritis is so often of specific origin, or the internist, because aortic aneurysm is now known as one of its consequences.

As to the establishment of an independent Department of Syphilis, I honestly believe there are serious objections. Specialization in medicine has continuously progressed and will undoubtedly continue to do so. Every practitioner has a right to arrange his practice to suit his inclina-

tion. If a physician will limit his work to diseases of the liver, or the pancreas, or cultivate only the surgery of the thyroid gland, or the stomach, or the rectum, we have no right to criticize his hobby. But should the medical schools follow suit and establish an unlimited number of independent departments? If syphilis is entitled to a distinct chair, why not tuberculosis, equally important and far-reaching in its effect upon the human economy? Why not diabetes, with its manifold medical, chemical, urologic, surgical and cutaneous aspects? Or cancer? Or leprosy?

I am not unmindful of the enormous growth of the subject of syphilis through the clarifying effect of modern research. But let me put the question of the proper teaching of syphilis in a nutshell: If any one of you were to write, today, a real comprehensive text book on syphilis, would you be willing or capable or bold enough to fill it with your own work from cover to cover? Would it not be wiser or more conscientious to entrust the chapter on specific eye affections to an ophthalmologist? Those of the nose and throat to the laryngo-rhinologist? The lesions of the nervous system to the neurologist? Those of the internal organs to the internist? And so forth. No doubt some of you have recently enlarged your former field. Some of you are experts in intraspinal injections. Some have given careful study to visceral lues. But does any one claim diagnostic and technical skill in all the different departments, including the eye, ear and nose and throat? Of course not!

And so it should be in our medical schools. Every department should retain its proper, limited, individual interest in the subject of syphilis. In fact no manner of regulation can ever change that. But the bulk of the teaching, the history, the general pathology, histology, serology, and the treatment of syphilis should remain with the chair of dermatology. Why with that and no other department? Because the inception of the disease is almost without exception upon the skin. The further phenomena in untreated cases are predominantly upon the outer integument, the mucous membranes, and in the superficial lymph glands. It is at this period that diagnosis and treatment are of paramount importance. If properly recognized and skilfully managed, it should be possible in many cases, practically to abort the disease and prevent the invasion of other organs; treatment begun at the right moment and persevered in, according to the best traditions, should reduce the affections of the eye, the nose and throat, the bones and the deeper organs, to an almost negligible quantity. It would be indeed an ideal state of affairs if by such timely treatment, syphilis should never develop beyond its cutaneous career.

And in the late, relapsing, inveterate cases we find again the outer integument as an important arena for the protean exhibitions of the disease. The pigmentary, serpiginous, ulcerative, nodular, gummatous, nail and tongue lesions have not been scared away by our modern diagnostic and therapeutic victories. The student needs here authoritative guidance, for there are diagnostic pitfalls in plenty.

The danger of duplication and overstepping in teaching the subject can easily be avoided by coöperation, coördination and tactful subordination. Unfortunately, coöperation is not overcultivated in our medical schools, where the teaching force rarely gets a chance to discuss such problems among themselves.

The present method of teaching syphilis is far from perfect. Before all there is not enough time given to it. But the greatest drawback is the lack of laboratory and hospital facilities. With a few notable exceptions there is in most hospitals in this country, where wards are open to medical students, not even a pretense of a special department for skin diseases and syphilis. Until there is a radical change in this respect, all our efforts, all our discussions and deliberations will remain academical. To the American student it has always been a revelation to find in the Hôpital St. Louis in Paris, in the General Hospital in Vienna, in Breslau and many other smaller university towns, hundreds of beds set aside for such cases. How we have been able to get along all these years without them, how we have given our students, with the aid of ambulatory material only, any kind of adequate instruction, is almost a mystery. Our immediate need, therefore, is, may I be permitted to say, preparedness. The next question, as to who should be in charge of the newly created armament can, to my mind, have but one answer. My "ceterum censeo" is: the Dermatologist, the proper Teacher of Syphilis.

CONGENITAL AND BONE SYPHILIS.*

By Abner Post, M.D., Boston.

When so comprehensive a subject is to be treated in the space of twenty minutes, it cannot be unwise to choose certain portions of the subject rather than attempt to cover the whole ground, and this title will be so modified as to read, "Certain features in the study of congenital syphilis." And this paper will concern itself only with such aspects or subdivisions as seem likely to prove of interest or arouse discussion. A few words in regard to Colles' law shall serve as an introduction.

Colles' law is so often misquoted that it is worth while to go back to Mr. Colles' original statement. It is as simple as the record of any naturalist of an observation of some natural phenomenon. He offers no explanation of the matter—he himself formulates no law. His observation is recorded in two different places and reads as follows:

"The following fact appears to me very deserving of notice: I have never seen or heard of a single instance in which a syphilitic infant (although its mouth be ulcerated), suckled by its own mother, had produced ulceration of her breasts; whereas very few instances have occurred where a syphilitic infant had not infected a strange hired wet nurse, and who had been previously in good health.

"It is a curious fact that I never witnessed nor ever heard of an instance in which a child deriving the infection of syphilis from its parents has caused an ulceration in the breast of its mother." (The New Sydenham Edition of Colles, p. 271.)

And again, in a little different language:

"One fact well deserving our attention is this: that a child born of a mother who is without any obvious venereal symptoms, and which, without being exposed to any infection subsequent to its birth, shows this disease when a few weeks old; this child will infect the most healthy nurse, whether she suckle it or merely handle and dress it; and yet this child is never known to infect its own mother, even though she suckle it while it has venereal ulcers of the lips and tongue." (New Sydenham Edition of Colles, p. 287.)

Naturally, other people sought an explanation and Mr. Colles has been unfortunate in his commentators. Apparently, Mr. Hutchinson was the first to speak of "Colles' law," and later the word "immunity" was used, but not in the sense in which it is now used. If we follow Mr. Colles accurately and formulate his observation into a law, it must be simply in some such form as this: "That a baby, born syphilitic, will not infect its own mother while it will infect a non-syphilitic wet nurse." It is a law based on observation and is not an explanation.

* Read before the 40th Annual Meeting of the American Dermatological Association, Washington, D. C., May 8, 9 and 10, 1916.

The pregnancies in a syphilitic family follow somewhat loosely a general course,—abortions, still-births, children dying shortly after birth, children that live as "hereditary" syphilitics, and later, if the births occur in a sufficiently long line, children that are healthy, apparently, at least. Two syphilitic families recently brought under my notice have younger sons who have passed the rigid examinations for enlistment in the regular army and navy.

An occasional exception to the usual sequence is worthy of note. The first-born of a syphilitic family occasionally survives,—syphilitic to be sure, and the often described sequence of still-births and early deaths begins with the second pregnancy. This first-born may be apparently healthy for many years, showing the first symptoms comparatively late.

These cases, so far as I can interpret them, are the cases in which a syphilitic father marries a healthy woman. The first child then is the offspring of a syphilitic father and a healthy mother, while the following children are the offsprings of two syphilitic parents. The first case of this sort that was brought to my attention was reported by me in 1898.

At the age of 22 years, when first seen by me, a young man had old interstitial keratitis and choroiditis. He was quite deaf. He died in the hospital from disease of the liver. The anatomical diagnosis at the autopsy was syphilis, atrophy of auditory nerves, gummata and diffuse syphilitic cirrhosis of the liver, gummata of abdominal walls, pancreas, lymphatic glands and bones of both lower extremities. His history was one continued story of syphilis from birth to death. The interesting part of his history, in this connection, is the fact that he was the first-born and was followed immediately by two miscarriages, a sister who died at one year of pneumonia, and one who died, at unrecorded age, of "congestion of the stomach." Five younger sisters and two brothers were then alive. In these living children, persistent headache and other symptoms were present which would call for serological investigation at the present day.

After the young man's death, the father voluntarily called upon the house physician, who had shown particular interest in the case, to tell him that he, the father, had had syphilis before his marriage and that he wanted to tell it in the hope that it might be of help. The mother had never shown any symptoms attributable to such disease according to her husband's story.

Similar cases have fallen under my observation in sufficient numbers to show that this was not an isolated case. Such cases will, I believe, always refer back to a father, syphilitic before marriage, and a healthy mother, and it is this supposed connection which has led me to introduce Colles' law and these cases of survival of the first-born, in this paper.

Cicatrices about the mouth are recognized as of frequent occurrence in hereditary syphilis. These are referred to as ulcerations in infancy. Some observations of late seem to justify the belief that they are occasionally due to intrauterine disease. When I have

made the observation that certain children must have had very sore mouths in infancy, the mother has occasionally disputed my statement, and careful examination of infants has occasionally shown cicatrices already existing, even in infancy. A photograph shows a baby's face with abundant ulcerations of the lips and about the mouth and on the cheeks. Marks, it may be, of ulcerations which were prenatal, possibly failures in development, similar to other defects, such as the failure of development of the nails, one example of which Dr. Wile published not very long ago.

One of the most constant symptoms of syphilitic infants is the difficult and noisy breathing known as "snuffles." It appears very early—sometimes it is present at birth. It varies from a troublesome sanguino-purulent discharge which excoriates the upper lip, crusts and obstructs the nostril, to a slight snuffling, noticed only at times. The obstruction to breathing interferes with nursing and sometimes makes it necessary to feed the child with a spoon. The baby smothers and chokes at night and sleeps poorly. It is known by all who have to do with syphilitic children and ought to be universally recognized; but while everybody knows about adenoids, not everybody recognizes syphilitic snuffles.

Adenoids. Few children with hereditary syphilis escape an operation for adenoids. The symptoms are the same, whether the breathing is obstructed by adenoids or by narrowed nasal passages, such as occur in hereditary syphilis. In syphilis, the relief is seldom obtained by operation and the operation is repeated a second and a third time. A newly consulted doctor is more apt to think that the preceding operation was imperfectly done than to look for any other explanation.

The upper jaw is known to lack proper development, so that the upper incisors fail to meet the lower, as was pointed out by Mr. Hutchinson in his observations on the deformity of the upper central incisors, known by his name. The very high arched palate is another example of a deformity in the same bones, and X-ray studies of the facial bones show that the nasal passages in syphilitic children are decidedly narrow, so that no amount of scraping away of soft tissue, adenoid or otherwise, can be expected to widen the passage.

The objection to operations on syphilitic snuffles, as for adenoids, is not alone that it is useless, but also that it exposes the physician to risk of inoculation. I have had the unpleasant duty of treating one enthusiastic operator for chancre of the finger. I have been told of another case, and even two cases are enough to warrant hesitation in doing an ill-advised and gratuitous operation.

Symmetrical synovitis of the knee joints was described, in 1885, as an

occasional result of hereditary syphilis. Within the past year it has occurred so often that it seems worthy of mention as a symptom which ought to be looked for. Synovitis of other joints, also symmetrical, occurs less frequently. Synovitis of both knees has occurred so frequently in connection with interstitial keratitis and Hutchinsonian teeth that such a triad seems of equal if not greater value than the famous triad of Hutchinson,—interstitial keratitis, deafness and notched incisors.

There is one phase of hereditary syphilis which demands our serious attention, and that is syphilis of the lung. I do not refer to the acute pneumonias of infancy, but to a chronic affection which simulates tuberculosis very closely, in its clinical history. A brief history of two cases will illustrate the class to which reference is made.

L. M., a girl of 18 years, has always been an invalid; is undersized, and suffers from interstitial keratitis, which obliged her to have an attendant when she first came to the clinic. She had a partial hemiplegia and some trouble with one hip joint which had been considered tuberculous, but it was not a destructive process. She had a cough and consolidation of one lung. She had spent time in the almshouse, in hospitals for tuberculosis and other hospitals; always considered tuberculous but tubercle bacilli were never found. She had a positive Wassermann. The entire left lung was consolidated, but the heart was not pushed out of place; on the contrary, it seemed to be drawn to the left. The right lung was practically free. The radiogram corresponded exactly to the picture presented by an acquired case, in which the diagnosis of syphilis had been practically established. She improved in every way under anti-syphilitic treatment, except that the lung condition changed hardly at all.

A boy of 10 years, Elias M., must be cited in this connection. He had four separate foci of consolidation—at each apex and at each base. He had been considered tuberculous, but he had not improved under treatment nor had he grown worse. A constant cough was his chief complaint. It was found that his sister had a positive Wassermann. The boy was then found to be Wassermann positive. There was a frightful infant mortality in the family. The boy was evidently a hereditary syphilitic and under treatment his pulmonary symptoms improved rapidly. The number of these cases is probably not very great, but it is appreciable.

The diagnostic signs of syphilis of the lung can hardly be absolutely formulated, but we may venture such a statement as the following:

When a case presents the rational signs of pulmonary tuberculosis, but the physical signs are unusual and no tubercle bacilli are found, a Wassermann test should be taken and certainly, if that is positive, a working diagnosis of syphilis may be made. If the Wassermann is negative, we may still consider the case worthy of careful study and perhaps of anti-syphilitic treatment. In the cases which I have cited a positive diagnosis of syphilis is warranted. These cases open up the widest field for research.

The coincidence of tuberculosis and syphilis in some of our patients presents occasional difficulties. That these two diseases may occur together is undoubted; that they are mistaken for each other is also true. They cause difficulty in the diagnosis of eye conditions, as they do in skin, bone and joint troubles. The family histories often mention tuberculosis in relatives of our patients and raise the doubt as to the possibility that the alleged tuberculosis was really syphilis.

The subject of the social relations of syphilities is attracting sufficient attention to permit its mention. The study of these cases has brought to light many instances of dependence: on grandparents; on uncles and aunts, as, for instance, a syphilitic child is supported by the husband of the mother's sister; on step-parents, including second marriage after death or divorce; on the State, as state minor wards,—children deserted by their parents, children adopted in infancy who have later developed symptoms of syphilis, no evidence of which was discovered in babyhood. These adopted children have brought out the most unselfish devotion on the part of adopted parents, who not only find themselves burdened with an unhealthy child, but also with whatever discomfort may be attached to the supposed parenthood of such a child.

When one talks of the possibility of transmitting hereditary syphilis to the third and fourth generations, as is so loosely done, he admits the survival of the first generation of hereditary patients up to adult age, and the possibility of such transmission is the subject of much speculation. On the other hand, there is apparently a wide belief that hereditary syphilities do not live to adult age, and there is a curious unwillingness to recognize syphilitic disease as hereditary in the adult. Such unwillingness to recognize adult hereditary syphilis is possibly one of the reasons why syphilities are so often believed to be liars.

Hereditary syphilis of adult life appears under several conditions.

1. Cases which have been known to the physician from infancy, in which the heredity is known, and the disease watched from infancy to adult life.

2. Cases seen first as adults, but with their history recorded by the stigmata of syphilis in unmistakable manner.

3. Cases seen first as adults without relatives, with doubtful signs and the question of heredity not easily determined.

The more cases of the first and second classes that can be seen and studied, the easier will be the solution of the problems of the third class. These are cases which are often made to suffer from unjust suspicions, or are not recognized at all. From the first series of children we learn that hereditary syphilities do grow up. That in adult life they show the

greatest variety in development and health, both physical and mental. Some justify all the serious things that can be said of syphilitics. Some are practically perfect. Medication seems to justify itself in certain cases, but it evidently is not the only element in shaping the adult life. Some of these cases carry with them their own diagnosis, as clearly read as can possibly be. Other children in the group present no sign of syphilis which would be recognized on very careful examination.

The second of our artificial divisions of these adult hereditary cases, consists of those in whom the recognition of syphilis and of its hereditary character is comparatively simple.

The case that did much to attract attention to this class came from one of the settlement houses. She is a scrub-woman, employed in part from charitable motives, as she can hardly be able to compare in working ability, with some of the robust women of her class. She was seen by the District Dispensary doctor, who told the authorities of the house that she was a syphilitic. They became alarmed and asked for information on the subject, particularly whether she was likely to infect others, and if anything could be done for her.

The case was that of Mary C., aged 33 years, a scrub-woman. She had marked opacities of the corneæ, extensive destruction of the soft palate, a nasal voice, and was quite deaf. There were Hutchinsonian teeth, extensive scarring on right lower leg, and the tibia was thickened. Her mother says she has been sick since she was six months old. She had been a patient at the Eye and Ear Infirmary, Boston City Hospital and Massachusetts General Hospital.

She had had an operation for abscess of the neck at six months of age. At present she has a discharge from the nose and noises in her head. She is an extreme example of hereditary syphilis. Hutchinsonian teeth, interstitial keratitis and deafness make the Hutchinsonian triad, which practically means heredity.

The question of danger to her surroundings is a remote one. She has, doubtless, spirochætæ somewhere in her body, but they are not so situated nor so numerous as to threaten her environment.

A second case is even more striking:

William B., aged 23 years (October, 1912). He suffered from interstitial keratitis and had been at the Eye and Ear Infirmary for 14 weeks—totally blind most of the time. He presents radiating scars at each corner of the mouth, most marked at the right. He has Hutchinsonian teeth and many scars on the lower legs, some of which are said to date from his tenth year. X-ray plates of the tibiæ show subperiosteal thickening, characteristic of syphilis. This young man has the signs of hereditary disease. There can be no doubt in diagnosis. His father was a drunkard, said to have died of consumption. His relatives are convinced that the son has acquired the disease and is lying to them, and all but an aunt have refused to help him. The stigma of the disease is visited upon him in a way more difficult to bear than the actual disease. Even when he tries to tell the truth, he is not credited.

Of the third class, the following is a good example:

Mrs. S. B., aged 20 years. Her parents died in England. She was sent to Canada with a sister. She knows nothing about the rest of her family.

Sept. 19, 1912. The woman is five months pregnant. She was picked up on the street, insensible, a few days ago and carried to the Relief Hospital, where they are said to have refused to keep her. Blood taken for a Wassermann test proved positive.

There was a superficial ulcer near the head of the tibia, syphilitic in character. The enamel of the upper middle incisors is very imperfect toward the cutting edge, making an arch which would make a Hutchinsonian sign if the thinner, imperfect cutting edge were broken away. She has one child who will be three years old in February. Her second child will be twelve months old in January. There is every reason to believe this woman to be a hereditary syphilitic.

The recognition of these cases is very necessary to the proper knowledge of the clinical history of syphilis.

FIG. 1. Rudimentary finger nails in hereditary syphilis.

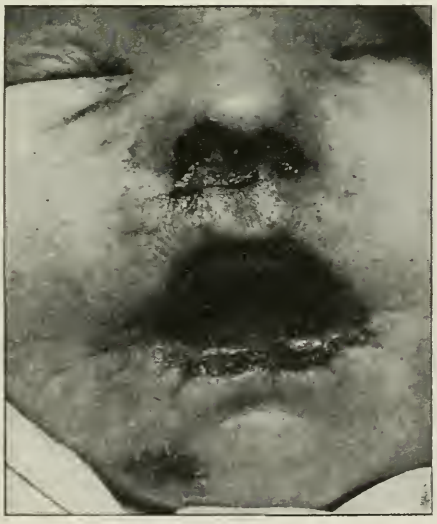

FIG. 2. Facial deformity in hereditary syphilis.

PASTES.

By Douglass W. Montgomery, M.D., San Francisco.

Pastes, like ointments, are mixtures of powders with fats, but with the notable difference that far more powder is present. They, therefore, differ widely from ointments both in their consisteney and in their physical action.

As a general rule in a paste, the powder or powders is equal in amount to the fatty medium; the best known of them is the one called Lassar's paste:

℞	Acidi salicylici.....	1.00
	Amyli	12.00
	Zinci oxidi..	12.50
	Vaselini	25.00

Lassar devised this with the idea that the eczemas were primarily infective diseases, which they are not. The discharges and the denuded surfaces, however, are extremely liable to infection and so contribute to the discomfort, to the intensity and to the prolongation of the eczema.

In the above combination the two powders, zinc oxide and starch, equal in weight the fatty medium, vaseline, and to this is added the antiseptic, salicylic acid, which, as we shall see, is a most astute device.

In this paste the large amount of powder, besides being light, gives the preparation the physical properties of porosity and absorbability proper to a powder, and the grease lends it consisteney, so that when applied it adheres to the surface and acts protectively, and furthermore holds the active antiseptic, salicylic acid, to the surface better than a powder.

Applied on an oozing surface, therefore, the paste, because of its absorbability and porosity, takes up the discharges, and so favors drainage, and at the same time brings these discharges in contact with the salicylic acid distributed in the mass of the paste, and so prevents their fermentation, and their consequent erosive, irritative action on the diseased surface. Very frequently, when the discharges are abundant, a powder, such as boric acid or talc, or a mixture of them, may be dusted over the paste.

The paste may be removed each day, which may be done with benzine, or if this irritates, with olive oil. It is frequently inadvisable to be too thorough in this cleansing for fear of breaking down the delicate epithelium and doing more harm than good. In many cases a superficial removal of the dressing with a reapplication of the paste is more judicious.

Besides the oozing, wet eczemas, the superficial, irritable, patchy papular ones are often better controlled by pastes than by ointments. The stiff dressing affords protection, and also seems to hold the papillary layer as in a splint. The hot, erythematous eczemas also often do well under a paste or a powder, because neither of these preparations interferes with evaporation, which is so important in keeping the surface of the skin cool.

A distinction must here be made between eczemas and impetigo contagiosa, which is a streptococcic infection that causes a lesion on the skin resembling a burn. The exudation quickly forms a crust, under which the anaerobic bacteria thrive wonderfully well. The pastes and the powders aid in the formation of this crusting, and therefore act contrary to one of the chief indications for treatment.

In order to comprehend why a hot, erythematous eczema may behave better under a paste or a powder than under a salve, it is well to consider, in this respect, the action of salves.

Salves, when buttered on lint and applied, tend to heat the already hot skin of erythematous eczema by retaining the heat and by preventing the evaporation of sweat. An experiment by Schäffer shows to a certain extent what occurs: he filled a flask with water, and poured in a little oil so as to form a thin sheet over the free surface. For weeks such a flask was allowed to stand in the incubator without the least evaporation taking place[1]. This is similar in its action to the layer of olive oil, with which the Romans used to seal their wine jars, before the use of corks was known. Pastes, therefore, in contrast to salves, may be said to give the maximum of protection with the minimum of asphyxiation.

Ointments and oils, however, when rubbed into the skin, and wiped off, and the surface powdered with an indifferent powder, such as talc, do not act in this manner, as under such circumstances evaporation of both heat and moisture go on unhindered, and the action in the depth of the skin, proper to an ointment, is also attained. There are people, though, whose skin is sensitive to fats of whatever nature, and with these a powder, a lotion or a paste, must be employed. This irritating action of fats is so frequent that Schäffer cautions to be on the alert for it when an ointment does not act well.

In choosing powders with which to make paste, undoubtedly oxide of zinc and starch are the favorites in spite of the fact that starch, being vegetable, is quite susceptible to fermentation. It is interesting to note in books on dermatology how frequently starch is mentioned. It is employed so frequently, in fact, that during the present war, at least one German journal devoted to skin diseases, requested that starch, on

account of being an important food, should not be used in cutaneous troubles. It acts particularly blandly on the skin, and mitigates the rather harsh drying effect of oxide of zinc, whereas the oxide of zinc on its part prevents the starch becoming too gummy. Starch is employed in powders, lotions, pastes and as poultices.

If it is desired to make a softer, smoother paste the proportion of powder may be lowered as:

℞ Amyli
Zinci oxidi..... āā 20.00
Vaselini 60.00

All sorts of powders may be added as medicaments to such pastes, with the understanding that the proportion between powder and fatty medium is maintained. For instance, if sulphur is added the prescription would read:

℞ Sulphuris 20.00
Zinci oxidi.....
Amyli, āā.....15.00
Vaselini 50.00

There is a paste, made of naftalan, that is particularly valuable in infantile eczema:

℞ Naftalan 50.00
Zinci oxidi.....
Amyli, āā..... 25.00

Naftalan is a Russian coal tar product, a coal black mass of the consistency of vaseline, which makes a paste that adheres well to the skin. In fact, on renewing the application, which should be done at least once a day, it is necessary, as with the other pastes, to use benzine or olive oil as a cleanser.

Unfortunately, the present war has interfered with the supply of naftalan, but tumenol may be employed as a substitute. Tumenol is a mild, antipruritic tar preparation that, as Schäffer says, very rarely irritates. It may be used in acute eczema in one to three per cent. strength, in subacute eczema in ten per cent. strength.

℞ Tumenol 3.00
Zinci oxidi.....
Amyli, āā..... 25.00
Vaselini 50.00

Several years ago I ran across a modification of Lassar's paste by Jamieson, which consists in employing glycerine instead of vaseline as the oily base. The formula reads:

℞ Acid salicylici..... 1.00
Amyli 12.50
Zinci oxidi 12.50
Glycerini 25.00

It makes a preparation of the consistency and color of thick white paint which spreads well, drifts into the skin almost like a powder, and holds its constituents tightly to the skin. It answers excellently in many superficial cutaneous inflammations, like poison oak. Not long since, an obese patient with a seborrhœic skin got a most tantalizing suppurative folliculitis of the lower limbs that was unusually refractory. After using many applications with no success, finally the above paste was ordered with the idea of drowning out the lesions. The relief was instantaneous, and the control was almost complete, as only a few pustules would appear from time to time. A given quantity of the preparation spreads over a larger surface than an ointment, and remains more permanently in place, and does not soil the clothing.

Boeck devised a combination that on the continent of Europe is called a paste, although in this country it is called a lotion. It consists of:

℞ Amyli .....
Talc āā..... 40.00
Glycerini 20.00
Gummi arabici..... 1.00
Liq. plumbi subacetas 4.00
Aquæ 200.00

It is what is commonly called a "shake mixture." It is easy of application, clean, and with the addition of ten per cent. of liquor carbonis detergens, is one of the best antipruritics I have ever employed. As a modification of this, Schäffer advises using equal parts of powder and fluid as:

℞ Amyli.....
Talc .....
Glycerini .....
Aquæ, āā..... 50.00

This approaches the above-mentioned modification of Lassar's paste with glycerine, as advised by Jamieson. It is, however, more fluid, less sticky and acts more like a lotion.

Because of the hygroscopic nature of glycerine, the preparations containing it make the skin damp and clammy, a sensation to which those having eczema are often particularly susceptible; they often shudder. In cold, damp weather, therefore, it may be inadvisable to spread them over a large surface. In warm weather their coolness is often an advan-

tage. In those who have an idiosynerasy toward glycerine, and there are many such, these glycerine preparations cannot be employed.

None of the pastes may be used on situations covered by thick hair, as the scalp, the pubes or the axillæ, as they make a felted mass, difficult to remove. They also should not be employed on mucous membranes, such as on the lips, prepuce or anus.

When starch and glycerine are prescribed the result is a peculiarly smooth mixture. Boiling these two ingredients together, however, makes quite a different substance, a jelly called a glycerole. Many years ago I prescribed Lassar's paste made with a glycerine base. The result was a crumbly mass that would not spread, and that had no effect on the skin whatever. I found that the druggist had boiled the starch and the glycerine together, and on being admonished, said that under similar circumstances he would do so again unless otherwise ordered. In other words, he had been trained to make the glycerole of starch. To avoid misunderstandings, a note may be appended to the prescription, ordering this not to be done.

Gelatine Paste. Other forms of paste are made by the addition of gelatine. These make casts, which, however, are lighter, more pliable and easier of application than those of plaster. Under certain circumstances these glues are wonderfully effective, especially in eczemas and ulcers of the leg, and in pruriginous affections in other situations, where it is desired to exclude the air, and protect the part from the injury of scratching.

The recipe I employ runs:

R	Gelatine	46.00
	Zinci oxidi	28.00
	Glycerini	12.00
	Aquæ	114.00
		200.00

The water should first be heated and the gelatine dissolved in it. Then add the glycerine and oxide of zinc and stir until cold. At room temperature it makes a solid mass.

The amount here, two hundred grams or over six ounces, is a convenient quantity to use on both legs. It should be dispensed in a deep jar that can be set in hot water to fluidify the contents just before applying. This fluid should be spread on the part with a spatula or wooden tongue depressor, and before it cools it should be covered with fleecy tufts of cotton that sink into the mass and make a felt. The hairs of the surface of the skin add also to this felting, and keep the application locked to the surface. It makes an excellent air-tight dressing. I

have seen itchy lichen-like eruptions, controllable in no other way, controlled absolutely for years with this simple dressing, which can be worn unchanged for two or three weeks.

In eczema or ulcer of the leg complicated with varicose veins, in order to get compression as well as protection, the glue is combined with a bandage. In fact, a weak point of the treatment is the breaking of the bandage at the ankle-joint, in a situation therefore basically important in the control of a sluggish circulation. As compression and support of the circulation from below upwards are of great importance in these cases, the bandaging should begin at the foot. The leg is well elevated and massaged toward the body to empty out the blood, and then washed off with alcohol or benzine. Still holding the extremity elevated, it is painted with the glue and bandaged with gauze, again painted and again bandaged until a cast of sufficient thickness is obtained. Here Schäffer[1] makes one of those practical recommendations that so often facilitates a procedure.

In ordinary bandaging it is necessary from time to time, to reverse the bandage so as to adapt it perfectly to the leg. A wet gauze bandage, however, reverses badly; it tends to twist and rope, and, furthermore, there is no object in reversing, as the bandage sinks into the glue, where it is held fixed in position. Instead, therefore, of reversing, the bandage may be cut off square and allowed to sink into the mass. One may then begin afresh with a new turn, and so on up the leg. If an ulcer is present that does not secrete too freely, a compress covered with a salve may be laid over it, and the whole included in the bandage, or a window may be made over the ulcer. In any case, even where secretions are present, maceration does not take place, as the glue is permeable by fluids.

A great objection to these preparations is the number of constituents they contain. They and their modifications are innumerable, and it would be impossible to memorize them. It is entirely practical, however, to learn the physical qualities of the constituents and to adapt them to the end that is to be gained. If this is done it gives an interest and an intelligence to the work that makes it a pleasure and not a toil.

[1] Schäffer, J. Therapie d. Haut u. venerischen Krankheiten, 1915, p. 17.

NÆVUS ANÆMICUS.

By John E. Lane, M.D., New Haven.

Nævus anæmicus was first described by Vörner, in 1906. He differentiated it from albinismus partialis, with which it had probably been confounded up to that time, and reported four cases. In September, 1914, Nanta and Lavau, of Audry's clinic, collected seventeen published cases and added one of their own, which was the first to be reported in France. None of the cases collected by them was from this country, and in my search for reported cases I was unable to find any in the English and American literature.

Case Report.

Mrs. D., aged 30 years, was referred to me in March, 1916, by Dr. Wilder Tileston of this city, for chronic paronychia of several months' duration. The nails of the fingers of the left hand were being shed and the new ones that were replacing them were apparently normal. The thumbnail of this hand had not fallen but showed marked transverse furrows. There was a mild, subsiding paronychia of the little finger of the right hand.

Aside from this, the history disclosed nothing abnormal. The patient had always been well. The routine physical examination, both by Dr. Tileston and by myself, also disclosed nothing abnormal, except a moderately enlarged thyroid, which had never given rise to any symptoms. The Wassermann reaction, made at the laboratory of the Connecticut State Board of Health, was negative.

In course of the examination some small white spots were noticed on the right cheek, concerning which the following statements were elicited: They were present at this time because the patient had chilled her cheeks by a walk in the cold air. They are plainly seen when the face is flushed by blushing, cold, heat or exertion, but at other times they are hardly perceptible. They have been present as long as the patient can remember, and her mother says that they have existed since birth.

There are six of these spots on the right cheek, the uppermost one about two and a half centimeters below the outer angle of the eye, the others grouped below it. They are all nearly circular in shape, but the borders are somewhat irregular. The largest is about one centimeter in diameter and the smallest about half as large. The vessels at the border of the largest spot are slightly teleangiectatic but otherwise the surrounding skin is normal. The skin of the spots themselves is normal except for the color. Hairs are present and of the same color as on other parts of the face. The pores are plainly visible and of the same size as those of the surrounding skin. Sensation is normal. Firm pressure with glass causes the spots to disappear, showing that there is no difference in the pigmentation. The patient was seen at a second visit, when the spots were less noticeable, and the application of hot water confirmed her statement that heat increased their prominence.

There is a striking similarity in the description of all of the reported cases of this affection. It is always discovered by the physician during

an examination for some other disease, as it is of so trifling importance that it does not bring the patient to a physician and does not lead him to mention it when he comes for something else. The spots occasionally occur singly, but usually are found in groups. The grouping frequently resembles that of the vesicles in herpes zoster. The spots appear anæmic, but in other respects are indistinguishable from normal skin. They are generally somewhat rounded and their borders are sharply outlined and somewhat irregular. The surrounding skin is usually normal but sometimes there are slight teleangiectases at the edges. The spots can easily be made more prominent by friction, by heat or cold, and by light cupping.

The ætiology and histological changes are uncertain. The affection is congenital, and there is never any history of disease or accident preceding it. The few histological examinations that have been made give varying findings. Vörner found the blood vessels smaller than in normal skin and the smaller arteries had the structure of capillaries. The sweat glands were smaller than normal and in the centre were apparently lacking. Otherwise the tissue was normal. From the structure of the vessels he concluded that the anæmia was caused by their inability to dilate. Fischer found no abnormality in the structure of the skin, and thought the affection rested on a functional basis, explaining it as a sluggish reaction of the skin vessels to dilatation in limited areas, and the opposite of cutis marmorata, in which the vessels are dilated and are sluggish to contraction. Stein thought that the actual number of blood vessels was diminished. Sprinzel calls nævus anæmicus, "the negative of the common nævus vasculosus" and thinks it is due to fœtal narrowing or obliteration of some of the vessels.

There is no difficulty in the diagnosis of nævus anæmicus if its characteristic points are borne in mind. The only other congenital affection with which it can be confused is albinismus partialis. It differs from this in the fact that there is no lack of pigmentation in the affected areas. The history always distinguishes it from the acquired conditions that resemble it. The examination also easily differentiates it in most cases. In scars, the skin is not normal. In leucoderma there is loss of pigment. In vitiligo and in leuco-melanoderma (syphilitic leucoderma), there is loss of pigment with hyperpigmentation of the surrounding skin. Glass pressure discloses these anomalies of pigmentation if they are not otherwise easily distinguishable. The rare condition, lues leukischæmia, described by Brauer and by Vörner, gives the same physical characteristics as nævus anæmicus,—white spots without pigment changes in the spots or surrounding skin. Vörner states that skin

changes of this type also undoubtedly appear, occasionally, in some cases of dermatitis and erythema. These are distinguished from nævus anæmicus by the fact that they are not congenital, but acquired; they are also usually attended by eruptions on other parts of the body; they usually change in size quite rapidly; they are not permanent, but disappear either spontaneously or with treatment. To these conditions, resembling nævus anæmicus, Vörner gives the name dermato-anæmia circumscripta acquisita, thus distinguishing them from nævus anæmicus, and from spots of depigmentation, congenital and acquired.

The attempt has been made to make the bibliography complete. Most of the references were given in Nanta and Lavau's article, but two or three of these have been corrected and one or two new ones added.

References.

Vörner, H. Ueber Nævus Anæmicus. *Arch. f. Dermat. u. Syph.*, 1906, lxxxii, p. 391.

Seeger. Ein Fall von Nævus Anæmicus. Thesis, Leipzig, 1908. (Not accessible.)

Fischer, W. Ueber Nævus Anæmicus. *Arch. f. Dermat. u. Syph.*, 1909, xcvi, p. 47.

Stein, R. Ueber Nævus Anæmicus. *Arch. f. Dermat. u. Syph.*, 1910, ci, p. 311.

Sprinzel. (Case shown before the Wiener dermatologische Gesellschaft, Sitzung vom November, 1910). *Wien. klin. Wchnschr.*, 1910, xxiii, p. 1891.

Brauer. Ueber ein seltenes syphilitisches Exanthem (Lues leukischämica.) *Arch. f. Dermat. u. Syph.*, 1911, cvi, p. 85.

Vörner, H. Zirkumskripte Dermato-anämien (Leukischämien). *Arch. f. Dermat. u. Syph.*, 1912, cxi, p. 149.

Bruner. Nævus Anæmicus. *Gazeta lekarska*, Warszawa, 1912, 2s., xxxii,, p, 363. (Not accessible.)

Nanta et Lavau. Sur L'angio-nævus anèmique. *Ann. d. dermat. et d. syph.*, Aug.-Sept., 1914, v, p. 472.

Bruner, E. Nævus Anæmicus. *Ikonogr. Dermat.*, 1914, vii, p. 277.

Vörner, H. Zur Kenntniss des Nævus Anæmicus. *Arch. f. Dermat. u. Syph.*, 1915, cxxi, p. 368.

CLINICAL REPORT.

ARGYRIA FROM AN UNUSUAL SOURCE.

By A. Davidson, M.D., Los Angeles.

P. D. contracted an acute gonorrhœa before he acquired the knowledge that he who treats himself has a fool for a physician, so he promptly began injections of argyrol in ten per cent. solution.

Three weeks after he began treatment, he noticed the back of his hands becoming "reddish" and thought they felt cold. In six weeks they attained their present bluish color. They feel cold to the touch and are distinctly leaden colored, especially over the knuckles. The whole body is of a muddy tint, the nose, cheeks, thighs and hands showing more markedly the bluish discoloration. There is no line on the gums, except on the two lower incisors, where there is a deposit of tartar. The hair is unchanged.

The coloration, etc., is similar to many others described, but there are three unusual features in this case. I have seen no record of argyria from urethral absorption. Argyrol being an albuminate of silver, it is supposed to be impossible of absorption. Three weeks is a short time in which to produce argyria by local application.

He used urethral injections three times a day, retaining the same for five minutes. During the period prior to his coming under observation, he used, so far as he can recollect, the following amounts: Argyrol, 4 oz., at 10 per cent., 2 oz., at 25 per cent., 2 oz., at 30 per cent. Protargol, 4 oz., at 10 per cent. Albargin, 4 oz., at 5 per cent.

There is probably no portion of the human body from which absorption is as rapid as from the urethral surface. One quarter grain cocaine, injected into the deep urethra, will frequently cause immediate alarming symptoms and occasionally collapse, and the rapidity with which so-called catheter fever will develop, all indicate that the urethra has unusual capabilities for absorption. It is possible that in this case there may have been some solution of continuity in the mucous membrane, that facilitated absorption.

Up to the time of the first appearance of the discoloration, he had used 800 grains of argyrol and 200 grains of protargol, a total equal to 400 grains of metalic silver, but as only a small portion of this amount could possibly be absorbed, the argyria must have been produced by a comparatively small amount of the metal.

My experience with argyrol has led me to consider it of no more value than vaseline or any other such lubricant; perhaps it has some potentialities for good as well as evil.

CORRESPONDENCE.

TREATMENT OF TINEA BARBÆ.

To the Editor:

The average physician realizes how rebellious to treatment is the nodular or lumpy form of trichophytosis barbæ. I refer especially to the individuals who present themselves for treatment after the usual patent and domestic remedies have been tried. This is accurately described and illustrated in Ormsby's "Diseases of the Skin," page 888. At this stage we are confronted by one or more boggy, fluctuating tumors in size from a hazelnut to a walnut, with pus or a gelatinous fluid exuding from several sinuses. These circumscribed lumps are in various stages of softening and usually are limited to the chin, one cheek or directly under the ramus of the jaw. The hairs are easily epilated and the roots are club-shaped, swollen, and many times larger in diameter than the other portion of the hair. In the last five or six years I have treated twenty or more cases, including a number of kerions in children. During this time I have had no failures and the average number of treatments by the method I have successfully adopted rarely exceeds three or four. Two cases of kerions, as described recently by MacKee and Remer in the *New York Medical Record* for August 7, 1915, which had been running a month each, were cured in two weeks with one treatment in the one case and two in the other.

Recognizing the utter futility of trying to force the usual parasiticidal remedy into the focal centre of a boggy pus-laden tumor the size perhaps of a filbert or larger, I began the injection of tincture of iodine into every portion of the infected area. Preceding the iodine the mass is filled with a solution of novocaine and in ten minutes the iodine treatment is begun. Every part of the diseased area is loaded with iodine until it trickles from every sinus. If the tumor is on the cheek I insert a finger into the patient's mouth to steady the tumor and it is then thoroughly filled with iodine. Often I use a second syringeful, employing the common glass-barreled, hypodermatic syringe with a steel needle until I am assured every part is well injected. With children it has been my practice to use a few whiffs of ether followed by novocaine, then the iodine. The reaction is moderately severe. The patient is ordered to return in four or five days, as soon as the immediate soreness disappears, and if any part of the fungus growth shows vitality another injection is given. No other treatment is given although it is policy to use the regular application of any of the usual ointments.

My experience in the treatment of this stubborn disease is limited, falling to my lot only in the course of a general practice. I do not offer this as a specific but I do insist that I have cured all my cases speedily and without worry and I offer it to the profession for what it is worth.

Very recently I treated another case of this affection. It was of four weeks' duration when he came to me and there were a number of sinuses. When I injected the iodine there seemed to be quite an excavation already formed. The first injection destroyed all semblance of the infection but quite a cavity resulted which is now about healed. This case got three injections—the third was really superfluous. I have never seen the treatment mentioned in any text-book or article.

Very truly yours,

W. M. Beck, M.D., Clarkfield, Minn.

SOCIETY TRANSACTIONS.

NEW YORK DERMATOLOGICAL SOCIETY.

Regular Meeting, Feb. 15, 1916.

HOWARD FOX, M.D., *President.*

PRURIGO NODULARIS. Presented by DR. WILLIAMS.

The speaker said that he had presented this case before the American Dermatological Association and that the history had already been published in the *Amer. Jour. Med. Sci.* (September, 1915). As the condition was very rare, he thought it might interest the members to see the patient again. The condition had remained about the same, but a few new lesions had appeared and a small mass had developed in the left side of the tongue. The general condition was unaltered, and the itching was the same. The only change in any of the spots was suppuration occurring in some of the lesions on the legs, and was probably due to scratching.

DISCUSSION.

DR. FORDYCE said the case was a most interesting one and was very similar to the case presented by Dr. Johnston, some years ago. The entire picture in this case, however, was more intense. He suggested a blood examination, with the possibility of leukæmia as an underlying condition.

DR. MACKEE said that the number, the distribution, and the characteristics of the individual lesions were like those of the case presented by Dr. Zeisler, in St. Louis, three years ago. That patient also was a woman. The lesions also resembled, to some extent, Dr. Trimble's case of possible localized prurigo nodularis. Theoretically, the X-ray should be of some service in these cases.

DR. HEIMANN said that the main interest in this case was the consideration of its ætiology. If it were actually a prurigo, and hence in the urticaria group, it would be an anaphylactic disease. Leukæmia and pseudo-leukæmia, and, finally, tuberculosis, would have to be considered, and only a study of the blood, tuberculin tests, and microscopic examination of the lesions could clear up these points.

DR. TRIMBLE said that his patient, who had been referred to, was a young woman, twenty-four years of age, with lesions of just this nature on the outer aspect of the right thigh. She had been under the care of several physicians, Dr. Jackson being one. She wandered from one place to another and finally came to his clinic. The lesions were larger than those of the case shown, and the whole area exhibited a distinctly bluish tendency. She had any number of different forms of treatment, among them, the X-ray. The X-ray treatment, which was given several years ago, caused a great number of teleangiectases; making it take on the appearance of a nævus. The lesions were all confined to

one location, the outside of the thigh. Carbon dioxide snow was tried on one lesion. It had been applied before, but apparently not sufficiently. Then he applied it to one of the lesions, and considerable necrosis resulted, forming an ulcer. Finally, each lesion was removed by excision. The patient was seen eighteen months later, and there had been no recurrence. The lesions were identical with those in Dr. Williams' case, but were localized to one small area. Excision, of course, was impossible in a generalized case.

Dr. Williams said that Dr. Trimble had spoken of one case occurring in a woman. Up to the present, all cases reported had been in women. His patient's blood had not been examined with any view to determining the leukæmic nature of the disease. Anaphylaxis had not been thought of, as typical urticarial lesions had developed from time to time, and on at least one occasion there had been an eruption of purpuric erythema. The patient had been badly constipated, had suffered from severe headaches, muscular pains after slight exertion, somnolence after meals, and other symptoms of intestinal toxæmia. These symptoms were all relieved by appropriate treatment, attention to diet, etc., but without effect on the nodules. Carbon dioxide snow had been used, but without benefit. Pilocarpine had been given to the point of toleration, without causing any improvement, and the same was true of arsenic, whether given by mouth or by intravenous injection. Weekly bleeding of 100 to 150 cc., followed by infusion of salt solution, had no apparent effect. The lesions on the tongue seemed to be unique in this case. So far as he was aware, none of the other cases reported had shown any lesions on the mucous membranes.

The patient to whom Dr. Trimble referred had a very chronic lichenification of the skin, and the tumors arose from the lichenified areas; and the whole process seemed to be due to pruritus and the resultant scratching. In prurigo nodularis, on the other hand, lichenification was slight or absent, and the tumors arose from apparently normal skin.

SYCOSIS VULGARIS ON UPPER LIP OF WOMAN. Presented by Dr. Trimble.

The patient was fifty-two years old and had hypertrichosis of the upper lip. In the centre of the lip was an area of pustular folliculitis, probably due, originally, to a nasal discharge. The hairs on the lip were unusually long and well developed. The lip lesion had existed for a year or more. Later, the eyelashes had become infected.

Discussion.

Dr. Heimann said that very frequently one saw a form of sycosis after epilation by electrolysis.

A CASE OF ULERYTHEMA OPHRYOGENES, MARKEDLY IMPROVED BY KROMAYER LIGHT APPLICATIONS. Presented by Dr. Clark.

The patient, J. S., was twenty-three years of age. He had always been generally well and strong. Four years ago, he first noticed a redness of the eyebrows, and had noticed for some time that the skin in the region of the eyebrows and on the forehead seemed to flush more than usual, on excitement or exertion. The eyebrows had thinned very considerably at the central and inner ends and had practically all fallen out at the outer third. The skin of the forehead, near the eyebrows and where the eyebrows had fallen, presented a thinly granular or pitted appearance.

This patient had had many kinds of applications that had been suggested in the literature for this disease, including some very strong antiseptic ointments, which resulted in the production of considerable dermatitis and peeling, without, however, any apparent effect upon the disease.

Four months ago, the patient began to receive Kromayer light treatments, exposures being made at a distance of two and a half inches, through a two millimetre blue filter and sufficiently strong to produce a mild "sunburn." Directly after this had subsided with the peeling that usually followed, another exposure was given, and the patient has had practically weekly exposures, over a period of three months. The patient had had no exposures for several weeks, but still showed some pigmentation from the light exposures, and presented a very marked improvement in his condition. The skin in the region of the eyebrows had lost its granular, pitted appearance, more new and fine long hairs had come in throughout the region of the eyebrows and particularly in the outer third, and numerous healthy, fine hairs seemed to be growing.

The case was presented before the Society at its October meeting, and was brought back to show a distinct improvement under Kromayer light treatment.

Discussion.

Dr. Wise said he noted a considerable amount of new hair over the outer third of the eyebrows. As he had very carefully examined the condition of the patient during his previous presentation before the Society, he was enabled to compare the extent of his alopecia upon the second presentation, and felt certain that a new growth of hair had taken place.

Dr. Trimble also thought the case showed improvement, as Dr. Wise had just said. He had noticed that erythema was still present, and was under the impression that erythema was the primary condition. If so, it would seem that any treatment which would increase the erythema would aggravate the condition. A year ago he had a private patient, a girl of fourteen, who presented an almost identical picture. Two or three attempts were made at treatment, and finally she was given a watery solution of resorcin, ten or twelve per cent. This was used for a short time, and then the patient disappeared and was not seen again until a few weeks ago, when she presented quite a little improvement. She stated that she had continued the resorcin treatment for some time. The erythema was still present. The case was very like the one presented by Dr. Clark.

Dr. Heimann said that if a restoration of hair growth could be produced in ulerythema ophryogenes, it was of more than mere therapeutic significance. A great many writers considered this disease a form of lupus erythematosus, and both clinical and microscopical findings favored this view. Thus, if the observations in this case were correct, it would be indicated that an atrophying process could be arrested and normal conditions reëstablished. He said that this was the first instance of this kind he had seen in this country, although the condition was not uncommon in Europe.

Dr. Whitehouse agreed with Dr. MacKee that the case could not be considered as cured, nor did he think Dr. Clark claimed that it was cured, but simply that it was improved. There were certainly new hairs on the outer third of the eyebrows, fine hairs coming out of what were funnel-shaped follicular openings. In his own opinion, there was distinct improvement. He had seen cases before, treated by resorcin, etc., used up to a considerable strength, but it only succeeded in cleaning up the plugged follicles. He did not agree with Dr. Fordyce that it was a great deal of trouble for a little thing. It was a good deal of a misfortune for one to have the eyebrows fall out and the follicles atrophy, and the condition warranted careful consideration on that

account. The erythema of which Dr. Trimble had spoken did precede the fall of the hair, and still persisted. In the history which Dr. Clark gave, mention was made of the attacks of erythema preceding the loss of hair. It was a question what this erythematous phase would eventually produce.

DERMATITIS EXFOLIATIVA. Presented by Dr. Wise.

The patient was a man, thirty-four years of age, who had been referred by Dr. Pollitzer for intravenous quinine injections. The lesions began six months ago as an erythematous patch on one thigh; they gradually spread, and four months ago a similar patch appeared on the other thigh, and then the condition became generalized.

On examination, the patient presented a uniform, diffusely reddened, moderately infiltrated skin, bearing small, adherent scales. In some regions the skin was tense and adherent to the underlying tissues. There was considerable emaciation, and the patient complained of intolerable pruritus. Quinine injections (½ per cent. quinine sulphate in salt solution) relieved the itching and improved the condition to some extent.

Discussion.

Dr. Heimann thought it was a case of pityriasis rubra of Hebra, or an exfoliative dermatitis. The histological picture would further indicate that it belonged to the erythrodermias, and since the condition appeared to have improved after the administration of quinine, the diagnosis of Wilson's disease seemed justifiable.

LUPUS VULGARIS. Presented by Dr. Wise for Dr. Fordyce.

The patient was a man, thirty-nine years of age, with a well-marked and widely spread lupus vulgaris, covering half the right side of the face. The lesion first appeared when the patient was seven years old. The point of its initial appearance was indicated by a distinct depression where the original patch had evidently been excised, though some diseased tissue must have been left and from this the lesion had extended. The patient had been sent by Dr. Saxe to the Vanderbilt Clinic for consultation.

MOLLUSCUM CONTAGIOSUM. Presented by Dr. Trimble.

The patient was a young man who had been tattooed on his forearm, seven months ago. One month later, the disease manifested itself. Two friends who were similarly tattooed at the same time, were also infected in the same way. There were great numbers of typical lesions situated in the tattooed area.

Discussion.

Dr. Fordyce said it was singular to note that molluscum contagiosum seemed to have an epidemic character. One can go along for years without seeing a case and then see several in close succession. He told of one case that he had seen with numerous lesions, followed closely by several others, although he had not previously seen a case for several years.

CASE FOR DIAGNOSIS. MYCOSIS FUNGOIDES? Presented by Dr. Kingsbury.

The patient stated that about three years before, itching "blotches" appeared all over the body and remained for two or three months, new lesions appearing progressively. The papules were of an eczematous character and pruritus was marked. The condition had grown steadily worse. She had been treated, but without any benefit.

Discussion.

Dr. Trimble thought it was a case of mycosis fungoides, possibly just beyond the pre-mycotic stage.

Dr. Wise agreed with Dr. Trimble, as also did Drs. Whitehouse and Fordyce.

Dr. Heimann agreed with the previous speakers, that it was a case of mycosis fungoides, not only clinically but microscopically. The only other thing that suggested itself from the microscopical picture was that it was parapsoriasis. It lacked some of the features of premycosis, emphasized by Unna. The picture consisted prevailingly of lymphocytes and a few mast cells, but no vascular changes of any moment, or giant cells. Clinically, there seemed to be no doubt but that it was a case of premycosis.

Dr. Howard Fox agreed with the other speakers that it was clinically a case of mycosis fungoides. There was more objective evidence of itching than was usually seen in this disease.

DERMATITIS MEDICAMENTOSA. Presented by Dr. Kingsbury.

The speaker stated that the patient had only just come to the hospital and was presented as an example of dermatitis due to absorption of a drug from the skin. It was evidently a case of dermatitis medicamentosa,—probably from the application of belladonna plaster to his back. The eruption was distributed chiefly on the trunk and consisted of numerous macules and small papules, together with patches of erythema.

Discussion.

Dr. Fordyce regarded the case as a dermatitis venenata or medicamentosa, due to the application of a belladonna plaster. A few days before, at the City Hospital, he had seen a generalized scarlatiniform erythema involving the entire body as well as the mucous membranes of the throat, resulting from the application of tincture of iodine, over a limited area of the skin. In this case, the patient had an elevation of temperature which lasted for several days. The condition simulated a scarlatina.

Dr. MacKee was not convinced that it was a case of dermatitis medicamentosa. The patient had applied the belladonna plaster, and a little later the eruption appeared locally and later spread over the entire body. That would suggest the possibility of dermatitis venenata. The one condition was the result of an external irritation; the other was the effect of the drug after it had entered the system by absorption, injection, or ingestion.

Dr. Trimble, referring to Dr. MacKee's remarks, asked if Dr. Kingsbury had not presented the case as one of systemic absorption of the drug, locally applied.

Dr. Whitehouse said he did not wish to split hairs on nomenclature, but he agreed with Dr. MacKee that it was a dermatitis spread over the skin by an irritant drug, and not a general efflorescence from belladonna, as would appear from absorption from the plaster. So it impressed him.

Dr. Heimann said that as a matter of convenience, the distinction made by Drs. MacKee and Whitehouse was good, but that it was biologically unsound. Whether the portal of entry of toxines was the gastro-intestinal tract or the skin, made no difference, since in any case the disease was systemic. He said he had seen two other identical cases within the previous three days, all caused by the use of belladonna plasters. The eruption had begun at the point of application and the disease had rapidly become systemic. It was a frequent occurrence to find systemic reactions to the local use of quinine, as, for instance, in hair washes. Ingestion was not a prerequisite for systemic involvement. So far as he understood the question, it was one of allergy.

Dr. Wise said his understanding was that the man had applied the belladonna plaster and had absorbed the drug, and that a rash resulted from absorption. He had seen a case of iodine poisoning from the application of iodine-petrogen to an area of skin the size of a fifty-cent piece. The patient had a papular eruption which a physician diagnosed as smallpox, and a temperature of 104° F. The area over which the iodine had been applied was not more inflamed than the rest of the skin.

Dr. MacKee said that it did not strike him as an eruption due to a drug acting from within. In the case referred to by Dr. Wise, there was a typical iododermia, showing that the drug had been absorbed into the circulation and was affecting the skin just as though the stomach had been the portal of entry. If the iodine had caused an eruption through its local irritating properties, the dermatitis would have been eczematous in character. Belladonna, when affecting the skin from within, produced a sudden outbreak of generalized scarlatiniform erythema. In the case in question, there was a catarrhal dermatitis, beginning at the site of the plaster and spreading to other parts, just as one would see an occupational dermatitis and dermatitis from other causes, such as hair dyes, poison ivy, etc.

Dr. Heimann expressed the opinion that there was much in what Dr. MacKee had said, but that it rather supported his own contention. At the point at which the dermatitis occurred, there was a very good field for absorption through the broken skin, and this might be part of the very mechanism by which the whole anaphylactic reaction was produced.

Dr. Trimble said that he had been much interested in Dr. Heimann's first remarks about the case and wished to know if he considered the case analagous to the hair-dye eruptions spreading over half of the body. The port of entry did not make much difference, but he would like to know if Dr. Heimann considered that it belonged to that class of eruption and, if so, whether he considered it as the absorption of the poisonous product of the hair dye or as peripheral spreading of the inflammation.

Dr. Heimann replied: Probably both. There was absorption, or one would not see such febrile reactions, such as Kaposi recorded in acute dermatitis. The second possibility was an extension of the process from the site of application. Every one knew that when hair lotions were applied to the scalp a dermatitis may develop far beyond this site.

Dr. Howard Fox felt that there had been a good deal of hair splitting in the discussion. He thought it likely that the eruption was due to an external irritant. There was no history, however, of the characteristic belladonna symptoms, such as dilated pupils, dry mouth, and scarlatiniform rash.

Dr. Kingsbury agreed with the opinion expressed by Dr. Wise. It was peculiar how differently different persons viewed the same eruption. When he first saw the case during the day, his whole impression was that it was a case of dermatitis medicamentosa. It was a generalized eruption suggesting measles; then, going into the history, he found that the man had applied a

belladonna plaster. The irritation there, was not much greater than on the other parts of the body. The question of the hair lotion dermatitis was largely speculative. Both views had been advanced about its spreading. In some instances it was undoubtedly absorbed; in others, it was purely local extension.

Dr. Fordyce reported a very interesting case of dermatitis involving the face and neck, which followed the use of a hair dye. In addition to the skin manifestations, the patient suffered from vertigo and headaches, and had been sent to various health resorts to be cured of these symptoms. Dr. Gilman Thompson, who saw the case with him, had investigated the chemistry of the dye and found that the German Government had prohibited the sale of this particular product on account of its toxic properties.

Reports of Cases Previously Presented:

Dr. Whitehouse reported on a case which he had previously shown of what he then thought was hæmorrhagic erythema multiforme, but which was regarded by most of the members as a case of purpura. The young woman stated that she had had the lesions several months and that when they recurred, they always appeared on the same areas. He had just been informed that the patient had returned with some acute lesions on the identical pigmented areas that she had shown before, and that these were erythematous hæmorrhagic plaques, with some thickening. It seemed to be an anomalous type of purpura. An infiltrated erythema rising out of the same pigmented spots was peculiar in any case, and he hoped to be able to follow it further.

Dr. MacKee said that two or three months ago, there were two cases of possible lichen atrophicus shown at the same meeting. The exhibitors promised to make histological studies and report later. It would be interesting to know the result.

Dr. Trimble said that with the consent of Dr. Williams, he could report on one. The patient had been shown by Dr. Williams at a previous meeting. The patient was a young man with one or two lesions on one forearm and one lesion on the other. These lesions were the size of a split pea, had a narrow raised border, and were seemingly atrophied in the centre. The section had been very carefully studied, but it had not been possible to reach a diagnosis. It could be said, however, that it was not lichen planus. The specimen showed a good deal of blood pigment, very little infiltration, and apparently some atrophy. Dr. Heimann had been asked to look at the specimen, and in the main agreed as to the findings.

Dr. Heimann said that the collagen was swollen peripherally, atrophied in the centre, and that the skin glands were absent. Where the collagen was swollen, it had the appearance of that seen in the early stages of scleroderma. There was no marked infiltration, as in lichen, and the lesion strongly suggested morphœa.

CHICAGO DERMATOLOGICAL SOCIETY.

Regular Meeting. Dec. 21, 1915.

F. G. Harris, M.D., *President.*

VON RECKLINGHAUSEN'S DISEASE. Presented by Dr. Ormsby.

A young woman, aged thirty, a trained nurse, had had the disease for 22 years. The tumors were small, the largest about hazel-nut size, and nearly all were sessile. The peculiar bluish appearance and the ease with which they

could be pushed back into the skin were striking. Interspersed among the tumors were various sized areas of pigmentation. Many of the tumors presented the peculiar nipple-like appearance. The presence of the lesions on the face in this instance was a source of great concern to the patient.

A stained section from one of the tumors, made by Dr. Stillians, showed the typical histological picture presented in this disease.

Discussion.

Dr. Pusey remarked on the fact that a deficient mentality, which was supposed to be common in these cases was often lacking, and called attention to this patient, who was mentally bright, as illustrating this fact. He thought that some of the face lesions suggested those of adenoma sebaceum.

Dr. Foerster mentioned three instances in which he had seen adenoma sebaceum and von Recklinghausen's disease in the same patient.

Dr. Harris said that he believed that the histology of von Recklinghausen's disease was distinctive and different from that of the ordinary fibroma molluscum.

RAYNAUD'S DISEASE. Presented by Dr. Ormsby.

A male, aged 27, had had the disorder for three years. He complained of poor circulation in both hands and feet. For the past three years the toes of the left foot had been cyanotic and from time to time ulcers appeared, which gradually healed. He complained of quite severe pain within the toes. Season was stated to have had no effect on the condition.

On examination, the relics of ulcers were seen and all of the toes of the left foot and the fifth toe of the right foot were found cyanotic. The Wassermann reaction was negative; blood pressure, 124.

Discussion.

Dr. Baer said he believed that the case was one of circulatory disturbance followed by necrosis.

Dr. Foerster said that he would consider it Raynaud's disease; but would not pronounce a final diagnosis without more study.

LUPUS ERYTHEMATOSUS. Presented by Dr. Pardee.

An actor, thirty years of age, who had lupus erythematosus 9 years ago, had had a vesicular eruption on the face for several months. The eruption began on the nose and spread peripherally to the cheeks. Then new areas of erythema, with grouped vesico-pustules, appeared on the forehead, neck and ears. It had improved at times under treatment with antiseptic ointments, but always recurred. The eruption on the hands had been noticed only about three weeks. A vesicular eruption was grouped over the nose, the flush areas of the cheeks, the ears and the forehead. The lips were scaly and cracked. Both palms and soles were covered by deep vesicles, and on the backs of the fingers a raised, red area extended down to the first joint, with a marked paronychia.

Discussion.

Dr. Pardee said that though he had considered the case one of impetigo added to lupus erythematosus, he now thought that it was all undoubtedly lupus erythematosus.

Dr. Pusey thought that it was not necessary to invoke a secondary infection to account for the lesions. It may be all lupus erythematosus, including the pustular dermatitis on the hands and the paronychia.

CASE FOR DIAGNOSIS. NODULES ON THE FACE OF A NEGRO. Presented by Dr. Shaffner.

The patient was a young man with about twenty scattered lesions on the face and eyelids; they were spherical, translucent, glistening, some flat topped, almost gelatinous in consistency, and were present for about six months.

Discussion.

Dr. Pusey considered the case to be one of keloids.

Dr. Harris thought the tumors might be endotheliomata.

URTICARIA PIGMENTOSA. Presented by Dr. Stillians.

A baby girl of 17 months had had the disease since she was three months old. The child was covered by soft, flat, round, slightly raised papules, chamois colored or darker, which reacted on irritation with the formation of wheals. No signs or history of itching. It was interesting to note that the mother gave a definite history of mild epidermolysis bullosa since her own childhood.

MULTIPLE PIGMENTED TUMORS OF THE SKIN. Presented by Dr. Simpson.

A man of 28 years had a pigmented mole "clipped off" his back in 1905. It was the size of a hazel nut. Recurring five months later, it was again cut off, but a year later recurred again and grew to half walnut size. An excision beyond the apparent border of the tumor was then made, and the wound left to granulate, leaving the scar seen in the lower dorsal region, over 3 by 2 inches. In september, 1914, nine years after the original operation, the first of the present crop of tumors appeared on the neck, and since then they steadily increased in number and size, until he had about forty, from pea sized to the size of a hen's egg. The superficial ones were bluish black: the deeper ones showed bluish through the overlying skin.

Discussion.

Dr. Pusey said he would consider them melano-sarcomata.

Dr. Ormsby said that he rather favored the view that these were nævo-carcinomata.

SCAPHOID NAILS, CURED. Presented by Dr. Harris.

Three months before, the colored man, 38 years old, presented himself with typical scaphoid finger nails. The central depression was very well marked, and caused pain, seemingly due to pressure on the nail bed.

Discussion.

Dr. Pusey congratulated Dr. Harris on his result and asked him to tell how he obtained it. He knew nothing that affected these nutritional disturbances of the nails as a rule.

Dr. Harris replied that the treatment was a salicylic acid and oil of rusci ointment. To what other factors the improvement was due, he did not know.

ACTINOMYCOSIS OF THE NECK. Presented by Dr. Harris.

The patient was a man, 34 years old; for 19 years he had a suppurative condition of the glands of the neck. He had had four operations and internal treatment. One month ago, when first seen, there was a discharging sinus along the anterior border of sterno-cleido-mastoid muscle at the level of the cricoid cartilage. The pus was thick and contained yellow granules, which were found to be actinomyces. X-ray treatment and potassium iodide produced a cure.

REACTION OF SKIN TO INJECTIONS OF AGAR. Presented by Dr. Stokes.

This case was shown for the purpose of getting the opinion of the members on the resemblance of the lesion to a luetin reaction. The lesion consisted of a raised papulo-pustule with a central, slightly scaling crust, situated below the deltoid insertion on the right arm. This was the fifteenth day and the lesion was then undergoing involution. The patient was in the secondary stage of syphilis, with a positive Wassermann, and had been under vigorous treatment with mercury salicylate injections. Under similar conditions luetin had been known to produce positive reactions. The reaction in the present case was produced by 0.1 cc. of a 1% suspension of agar. The patient had not been receiving iodides. The speaker stated that in the course of experimental studies in intradermal sensitization, he had found reason to believe that the specificity of certain cutaneous tests, and especially of the luetin reaction, could be attacked. That is, they could hardly be regarded as purely antigen-amboceptor reactions in accordance with the older conceptions of the Friedberger school of immunologists. He had succeeded in producing fairly good clinical imitations of the luetin reaction with injections of sterile agar, and of skin emulsions in late syphilis, regardless of the use of potassium iodide. Such reactions apparently did not occur in normal persons, or in such dermatoses as psoriasis. The explanation advanced by the speaker for such phenomena was that of a local adsorption of anti-ferments by the injected substances. This adsorption of the protective agents in the skin or serum, uncovered proteolytic ferments at the site of injection, whose action then gave rise to autolysis with anaphylatoxine formation and inflammation. The speaker ventured the belief that such studies might throw considerable light upon the immunity mechanism and on the allergic phenomena of late syphilis, and stated that he was conducting experiments along these lines, and that some of the results were in process of publication.

ECTHYMA. Presented by Dr. Pusey.

The patient was a man of 55 years, with ulcerative lesions over the body and limbs for the past 10 months. He had had diabetes since 1907, and his right leg was amputated in 1914, because of diabetic gangræne. A doubtful history of syphilitic infection 20 years ago was given, the patient appeared in poor health and presented multiple, angry looking ulcers, from the size of a split pea to that of a nickle, surrounded by slight induration and covered by bloody

crusts. Scars of previous lesions showed hyperpigmentation. Scratch marks were present. The Wassermann was positive. The urine was heavy with sugar.

Discussion.

Dr. Ormsby said that some of the lesions appeared to be factitious, though most of them could hardly be placed in that category. The case did not present the usual characteristics of dermatitis factitia. He was in doubt as to the proper placing of the disorder.

Dr. Foerster noticed that all the lesions could be easily reached by the patient. The fact that the man had diabetes should not be forgotten.

Dr. Heidingsfeld thought it a late, secondary, ulcerating, papular syphiloderm.

Dr. Harris said he considered it a case of dermatitis nodularis necrotica; that he had had a case some time ago, a young man apparently in robust health, who developed nodules that became gangrænous in the centre, leaving slowly healing scars.

Dr. Pusey considered it to be a case of gangrænous ecthyma in a cachectic, diabetic patient.

MANHATTAN DERMATOLOGICAL SOCIETY.

Regular Meeting, Jan. 14, 1916.

George M. MacKee, M.D., *Chairman.*

ERYTHEMA MULTIFORME PERSTANS. Presented by Drs. MacKee and Wise.

The patient, a female adult, had been shown before the Society in March of the previous year, as a rather unusual type of erythema multiforme. This eruption, instead of running its usual course, had been persistent, so that the speakers had changed their diagnosis, tentatively, to one of erythema multiforme perstans. The interesting feature, the speaker said, was not so much the persistence of the lesions which could be seen on the patient's face and upper extremities, as the formation of verrucous growths, which appeared over the sites of the original lesions. They showed quite plainly on the face and arms. A biopsy had been taken and the slides were presented for examination. They exhibited chiefly a very marked dilatation of the blood vessels, additional new blood vessels and considerable round cell infiltration in the corium; Dr. Wise said there was a possibility of this being a tuberculous lesion. The case was presented as an erythema multiforme perstans, with superimposed lesions of a verrucous nature. Some of the lesions had cleared up at one time under autogenous vaccines, but those on the face had remained for over a year.

Discussion.

Dr. Oulmann said that the microscopical picture of the section of this case reminded him of pictures of angiokeratoma. The only difference was that he did not find the stasis of blood and plasma in the widened vessels and lymph spaces, while the acanthosis as well as the keratosis were present and the cutis was in a state of inflammation. Also he believed that one or two lesions on the fingers could be regarded as angiokeratoma. He thought this case a combination of erythema multiforme and angiokeratoma.

Dr. Satenstein said he had studied some of the sections of this case when previously presented and found in them all the markings of erythema mutiforme.

CIRCINATE SYPHILIS. Presented by Drs. MacKee and Wise.

The patient was a colored female adult, twenty-nine years of age and married. She presented an eruption on the neck and parts of the face, which required very little description, the case being so characteristic, but the patient was shown because of the rather unusual, marked circinate arrangement. The speaker said the lesions began to clear up under the very first treatment, so that they were not nearly so distinct as when first seen. The duration of the eruption had been since the previous October.

KELOIDS. Presented by Dr. Oulmann.

The patient, a female adult, had received a severe burn from fire, eighteen months before. The lower part of both arms and the frontal neck and lower chin were one mass of keloids. As she could not raise the head, a plastic operation was performed and a flap from the upper arm was taken, and healed with splendid result. But the margin consisted of lines of keloid; where the flap was taken from, keloids also developed. The case was shown to demonstrate the predisposition for keloids, as the case was treated aseptically and antiseptically.

TUBERCULIDE. Presented by Dr. Parounagian.

The patient was a female, twenty-eight years of age, married and born in Russia. The family history was negative; she was apparently in good health. Her skin affection began about eight years previously, on the dorsal surfaces of the fingers. The lesions were symmetrical, extending up to her elbows and a few lesions on the extensor surfaces of both knees. There were a number of recent lesions and a great many older ones, dark-purplish in color, with necrotic centres. The case was a typical example of the disease.

Discussion.

Dr. Satenstein asked Dr. Oulmann what his results had been with the use of tuberculin. How many cases had he treated and how many von Pirquet reactions had been made by him, the speaker asked.

Dr. Oulmann answered that he lately did not have any cases of tuberculide. Of those cases mentioned in a former statement, he used the von Pirquet test as treatment only, five to six times, to get the result, while in others he used it up to eighteen times. In one case of mixed Bazin's disease and tuberculide, he used the Park, Davis and Co. tuberculin tablets, with excellent results.

LUPUS ERYTHEMATOUS. Presented by Dr. Weiss.

The patient was a female adult, who showed extensive lupus erythematosus lesions of the face and head. The speaker said that the disease was very rarely observed to be of such great extent on the head. The patient showed depressed, atrophic spots all over the scalp, with an absolute alopecia. The duration of the disease had been three years.

Discussion.

Dr. Oulmann said that the condition of the scalp was not exactly like that of lupus erythematosus in that locality. There they found a loss of hair, which was circumscribed, a red scaly skin with more or less central atrophy. Here

they found an almost entire loss of hair with very little atrophy, and the skin was thinned and showed numerous little blood-vessels. While he did not doubt the skin lesions being due to lupus erythematosus, he did not accept the scalp condition as lupus erythematosus alone.

Dr. Parounagian recognized the patient, whom he had treated some months previously at the Gouverneur Clinic. He stated that the condition had progressed since. The scalp condition he did not recall as the patient wore a tight wig at that time. She was very recalcitrant and did not attend regularly.

Dr. Weiss said that to him there was no doubt of the diagnosis of lupus erythematosus on the face, but on the scalp he took into consideration folliculitis decalvans; but there was here scar formation, atrophy and depression, while the peripheral portions carried no follicular elevations, as would be seen in that disease. The speaker said he had stated that there was no follicular atrophy, and thought that the two diseases may coexist.

PURPURA? Presented by Drs. MacKee and Wise.

The patient, J. M., was a male adult, twenty-two years of age, born in the United States; his family history was negative. He had been exhibited by Dr. Whitehouse at the Academy of Medicine, one year previously. Seven years before he was shown before the Society, the patient went camping in summer and when he returned home he found an eruption of "blood spots," limited to the upper extremities and axillæ. This eruption was preceded by no illness of any kind. The physical examination was negative and the patient appeared to be entirely well. He presented an eruption of purpura in the retrogressive stage, some of the lesions being pigmented spots and others true extravasations of blood, limited entirely to the upper extremities. The speaker said it was remarkable that lesions had been coming out during seven years and that they were limited to the upper and were absent on the lower extremities. The ætiology was obscure. The patient also presented an acne of the face.

Discussion.

Dr. Wallhauser said he was inclined to regard this case as one of parapsoriasis lichenoides, presenting an unusual feature in the hæmorrhagic lesions.

Dr. Satenstein said that the lesions in this case were transitory, which was not the history of parapsoriasis.

Dr. Oulmann said that if Drs. MacKee and Wise stated that the man had at certain times attacks of purpura, as the speaker's description showed, that was enough reason for believing that to be a fact. The patient had, besides, especially on the upper arms, some psoriasis-like lesions and small, striated atrophic patches on his skin. Some cases of psoriasis and parapsoriasis, he said, would be very hard to diagnose without further study.

Dr. Wise said that two things had to be taken into consideration,—first, that when Dr. Whitehouse presented this case it had been a true purpura and secondly, that at the clinic, when seen by the speaker, he also had a true purpura. The speaker had studied the literature on the subject of parapsoriasis and he had noted that purpura was not a feature of parapsoriasis. There may be an increase in the blood vessels, but no hæmorrhage took place in the skin. The speaker freely admitted, however, that the case looked like parapsoriasis of the guttate variety. He intended to remove a piece of skin for microscopic study.

ECZEMA ERYTHEMATOSUM. Presented by Dr. Weiss.

The patient was a male adult, who showed eczema erythematosum of the face, of several years' duration. The face was discolored and there were multiple melanotic warts on the eyelids and bronzed coloring of the skin, which gave an indication of adrenalin insufficiency, and he was put on small doses of suprarenalin. There was some puffiness of the face before treatment, with a subsidence of the condition afterwards. The skin of the face commenced to peel and the patient felt better. He had been observed for symptoms of Addison's disease, the speaker stated, as such blemishes were very often found in adrenal insufficiency.

Discussion.

Dr. Oulmann said that the pigmentation was seen not only in the face but also on the lower arms. This condition was seen in quite a number of people who were exposed much to air and light, probably due to influence of ultraviolet rays. Whether the pigmentation was brought on in people with abnormality in the secretion of their adrenal glands or in those with liver trouble, he was not able to state, but it was interesting to watch the effect of the treatment.

Dr. Weiss said he believed that sooner or later, dermatologists would have to get acquainted with the influence the ductless glands exert on the skin. The old French and English schools always held, without knowing anything about ductless glands and their deficiencies, that most skin diseases were due to some internal disorder, which caused the external manifestations. The Vienna school, under Hebra, ridiculed that as impossible. It was a well-known fact that the adrenals caused a great deal of trouble when they were deficient. Besides causing hypernephroma and Addison's disease, as the extremes of their affections, there were minor grades of their deficiency, not well observed yet and having great influence on the system and also on the skin. The patient presented simply an erythematous eczema of the face. The speaker would not say that adrenalin deficiency alone caused the eczema, but that by administering suprarenalin, the patient did get better.

Besides his pseudo-bronze color in the face, the speaker stated that this patient showed the regular adrenal hair distribution, with a tuft of hair over the sacrum and a tuft of hair in the nape of the neck. Those cases who had this distribution always had slight adrenal deficiency and some trouble with the glycogen secretion of the liver. By offering these casual remarks, which, the speaker said, were very incomplete, he only wanted to draw attention to the pathology and ætiology of the ductless glands and their correlation to the skin.

MINNESOTA DERMATOLOGICAL SOCIETY.

Regular Meeting, April 11th, 1916, held at St. Paul, Minn.

Burnside Foster, M.D., *President.*

MYCOSIS FUNGOIDES. Presented by Dr. Foster.

F. G., male, aged forty-five years. About eighteen months ago, he first noticed an eruption on the back of the legs near the ankles, which soon began to itch exceedingly and gradually spread to the upper part of both legs and thighs. A few months later, the same eruption appeared on the arms and wrists. The eruption was general on the extremities, with here and there a

patch on the body. The eruption was salmon-colored, slightly scaly in places, with a few indurated and very scaly spots on both buttocks. There was intense itching. The patient complained of chilliness.

GRANULOMA PYOGENICUM. Presented by Dr. Butler.

The patient was a male adult with a tumor-like mass, the size of a silver dollar, located on the chin.

Discussion.

Dr. Irvine stated that as the patient had had potassium iodide, the negative blastomyces examination would not absolutely rule out blastomycosis.

Dr. Olson agreed with the diagnosis of granuloma pyogenicum, and stated that about one year ago he had seen a granuloma pyogenicum exactly similar to this one, but located on the back of the neck.

SCLERODERMA. Presented by Dr. Butler.

The patient was a male adult with large patches of scleroderma on the neck.

PHLEBITIS LUETICA. Presented by Dr. Olson.

Male, aged thirty-five years. This patient had had a practically untreated syphilis for ten years. Infection was acquired in the Philippines. During the past year he had had "dropsy" of the right leg, the latter having been at times twice the size of the left leg. The right leg below the knee was markedly œdematous. The right long saphenous vein, near the groin, was thickened for a distance of five or six inches, so that it felt like a piece of rubber tubing. The Wassermann reaction was four plus. The patient showed marked improvement following five mercury salicylate injections.

Discussion.

Dr. Armstrong cited a similar case that he had seen, which involved the saphenous vein, in which the vein felt like a piano wire, and could be traced the entire length of the leg. This occurred in a patient with early secondary lues.

LICHEN SCLEROSUS ET ATROPHICUS. Presented by Dr. Sweitzer.

Miss U., aged twenty-one years. This patient had had the disease for three and one half years. The lesion consisted of a white, slightly elevated and infiltrated round area, on the nape of the neck. It was smooth and had no scales, but the surface showed an accentuation of the normal folds of the skin. Considerable itching was present. The lesion was fairly round and about two inches in diameter.

TABES AND LARGE SERPIGINOUS SYPHILIDE. Presented by Dr. Armstrong.

The patient, a male adult, had had very little treatment for syphilis. He showed typical tabes and a palm-sized serpiginous syphilide on the back. The patient was presented because of the rarity of skin lesions of syphilis in tabetics.

MYCOSIS FUNGOIDES. Report of Case by Dr. Thomas.

Numerous photographs and microscopic slides were shown from this patient, a male adult, who had large erythrodermia-like patches and some proliferating and ulcerating lesions on the abdomen. The slides were characteristic of mycosis fungoides.

SYPHILIS. MARITAL REINFECTION. Report of Case by Dr. Wright.

This patient acquired syphilis last fall, at which time he infected his wife. He had thorough salvarsan treatment last fall and winter. This spring he presented a typical primary lesion containing numerous spirochætæ of syphilis. Other exposure than with his wife was denied by the patient.

DISCUSSION OF AMERICAN, CANADIAN AND FRENCH SALVARSANS.

Dr. Wright stated that he had given fifty to sixty injections of diarsenol and had had no trouble when the diarsenol was given well diluted. In one patient, following the injection of a more concentrated solution, there had occurred marked shock.

Dr. Butler stated that he had given many injections of the French novo-arsenobenzol, with satisfactory results, although he preferred the German neosalvarsan.

Dr. Thomas said that at the Mayo Clinic he had given one hundred injections of diarsenol. More irritation in the arm, and greater systemic reaction resulted from the concentrated solutions, so that he advised the use of well-diluted solutions.

Dr. Freeman thought that the therapeutic efficiency of arsenobenzol was equal to that of neosalvarsan. He had given about fifty injections of arsenobenzol. One lot of the arsenobenzol gave rather cloudy solutions, but no ill effects resulted from the injections. He stated that he had found diarsenol more toxic than arsenobenzol. In one patient, after giving part of a dose of diarsenol, alarming symptoms,—spasm of the muscles, unconsciousness, weak pulse, vomiting, etc., followed. This patient recovered and was all right the next day.

Dr. Irvine had given more than twenty-five injections of arsenobenzol. Vomiting in one case, and some shock, rapid pulse, etc., in another occurred, although the reaction in neither patient was severe.

Dr. Foster suggested that some of the reactions might come from the salt solution or water, and Dr. Thomas stated that at the Mayo Clinic slight disturbances had followed the intravenous injection of salt solution alone.

The consensus of opinion was that the German salvarsan was the least toxic of the salvarsans, and that the American salvarsan or aresnobenzol ranked next. The majority favored giving arsenobenzol in large amounts of water—180 to 240 cc.

REVIEW

OF

DERMATOLOGY AND SYPHILIS.

Under the direction of

FRED WISE, M.D., New York,

Assisted by

CLARENCE A. BAER, M.D., Milwaukee.
WILLIAM H. BAUGHMAN, M.D., New York.
PAUL E. BECHET, M.D., New York.
J. S. EISENSTAEDT, M.D., Chicago.
CHARLES GOOSMANN, M.D., Cincinnati.
JAMES F. GRATTAN, M.D., New York.
ROBERT C. JAMIESON, M.D., Detroit.
FREDERICK T. LAU, M.D., New York.
M. F. LAUTMAN, M.D., Hot Springs.
OSCAR L. LEVIN, M.D., New York.
M. L. RAVITCH, M.D., Louisville.
ISADORE ROSEN, M.D., New York.
MAX SCHEER, M.D., New York.
PHILIP F. SHAFFNER, M.D., Chicago.
A. W. STILLIANS, M.D., Chicago.
JOHN H. STOKES, M.D., Chicago.
HARVEY P. TOWLE, M.D., Boston.
VICENTE PARDO, M.D., Havana, Cuba.

DERMATOLOGISCHE WOCHENSCHRIFT.

(Feb. 19, 1916, lxii, No. 7.)

Abstracted by MAX SCHEER, M.D.

THE WASSERMANN REACTION IN THE PRIMARY LESION OF SYPHILIS.

H. HECHT, p. 145.

In the author's opinion the results of Bendig's investigations (*Dermat. Wchnschr.*, 1915, 1) do not in the least diminish the value of the Wassermann reaction. In primary lues the Wassermann reaction is the more apt to be positive, the longer the duration of the infection. A positive Wassermann reaction is very rare before three weeks after the infection. A positive Wassermann reaction, even in the absence of other manifestations, speaks for syphilis; the exceptions are well known and should always be kept in view.

(*Ibidem*, Mar. 11, 1916, lxii, No. 10.)

THE NATURE OF ECZEMA. SAMBERGER, p. 217.

Eczema differs from other superficial inflammatory skin affections clinically and (according to Unna) histologically. Brocq calls eczema an inflammation of the skin of "*special d'aspect.*" In eczema, according to Unna, the epithelial cells are compressed, but not necrobiotic and the vesicles are intracellular (spongiosis). In previous papers in this *Journal*, the author discussed the nature of inflammatory and lymphatic reactions. He believes that the clinical appearances of eczema can be explained by assuming a combination of inflammatory and lymphatic reactions, as the pathological basis. Usually the inflammatory reaction predominates; when the lymphatic reaction is in excess, lesions may result similar to those described by Neisser as urticarial eczema and by Martinotti as acute exudative œdema of the skin.

LUPUS CARCINOMA AND ROENTGEN RAYS. G. STÜMPKE, p. 226.

The first case was that of a man, 68 years old, with lupus vulgaris of 25 years' duration, on the right side of the neck. In the middle of this lesion was a cutaneous horn, two cm. long. The lupus lesions were treated first with pyrogallic acid salve and later with a sharp curette; the cutaneous horn, with three erythema doses of a moderately hard ray, given in the course of eight weeks. The therapeutic results were good. Three months after the X-ray treatment, a nodule appeared over the site where the cutaneous horn had been. A biopsy showed this nodule to be a squamous celled carcinoma. Its development on the area that was rayed suggested that the X-ray was the causative factor.

The second case was in a man, 58 years old, with lupus vulgaris of 25 years' duration, in the popliteal space. The lesions were curetted and the patient remained well for three and a quarter years. He then noticed a small nodule in the scar, for which a physician had given him 30 X-ray treatments—unmeasured and probably with a soft tube—over a period of five months. During the treatment the tumor grew rapidly. Biopsy showed a squamous celled carcinoma.

These were the only cases of lupus vulgaris that had received X-ray treatments. In 150 other cases under the author's observation, in which other methods were employed, he never saw a carcinoma arise. Lupus vulgaris should be treated surgically. Only inoperable cases should be rayed; the dose should be measured; a hard tube used, and the ray filtered.

ANNALES DES MALADIES VÉNÉRIENNES.

(April, 1915, x, No. 4.)

Abstracted by PAUL E. BECHET, M.D.

VIRULENT HEREDITARY SYPHILIS OCCURRING TWENTY YEARS AFTER SYPHILIZATION OF THE MOTHER. GAUCHER, BIZARD, BALZER AND DELCAMP, p. 193.

The authors report a case of hereditary syphilis manifesting itself forty days after birth by fissures at the angle of the mouth, mucous patches on the lower

lip, moist papules on the scrotum, and a vesiculo-bullous eruption on the right foot. The mother had had a syphilitic infection twenty years previously, and had been entirely free from specific symptoms for many years. The father was absolutely free from syphilis.

(*Ibidem*, May, 1915, x, No. 5.)

GUMMA OF THE TONGUE IN A HEREDITARY SYPHILITIC, NINE YEARS OF AGE, PRESENTING WIDELY SEPARATED MEDIAN SUPERIOR INCISORS. Gaucher, Bizard and Balzer, p. 257.

Report of a case.

(*Ibidem*, June, 1915, x, No. 6.)

CHANCRE OF THE PREPUCE WITH PHIMOSIS. Gaucher, Bizard and Bralez, p. 321.

The authors report seven cases of this type of chancre, which is usually situated on the entire circumference of the free cutaneous border of the prepuce, assuming a crown-like appearance. To the touch the induration is disc-like. The lesion is of a bright red color, bleeds easily, and causes a marked phimosis.

(*Ibidem*, August, 1915, x, No. 8.)

CHANCROIDAL BUBOES WITHOUT A PRIMARY LESION. Gougerot, p. 449.

Gougerot reports several cases of chancroidal adenitis in which the presence of the streptobacillus of Ducréy was demonstrated, without a chancroid being present. It is possible for Ducréy's bacillus to pass through the mucous membrane without leaving a visible trace of its passage, and cause infection of the inguinal glands.

CHRONIC CHANCROIDAL BUBOES. Gougerot, p. 459.

The author discusses the various varieties of chronic chancroidal buboes, but brings out nothing essentially new.

(*Ibidem*, September, 1915, x, No. 9.)

DEATH FROM INJECTIONS OF GRAY OIL. Gaucher, p. 513.

Gaucher mentions the fact of his having previously published statistics of twelve deaths following the injection of gray oil. He reports a case of a man, aged 50, who began treatment immediately after the appearance of the chancre. He first received ten injections of biniodide of mercury, which were well tolerated. The treatment was then changed, the patient receiving ten injections of gray oil, administered once weekly, each dose amounting to five centigrammes of mercury. The total dosage was fifty centigrammes. A very grave stomatitis supervened, the whole floor of the mouth was denuded and greatly infiltrated. The jaws were tightly locked, the breath exceedingly fœtid. Diarrhœa was absent. The pulse, while good, was intermittent. Death occurred in two days. In conclusion, Gaucher condemns the administration of gray oil.

(*Ibidem*, October, 1915, x, No. 10.)

THE ZOSTERIFORM SYPHILIDES. Gaucher, Bizard and Bralez, p. 557.

Under this heading the authors report their observations in 26 cases of papulo-squamous syphilides, which, instead of being irregularly scattered over the body, are grouped over the course of certain nerves, markedly simulating zoster. The similarity was only one of distribution and locality, however, as the lesions were not vesiculo-bullous.

RUSSKI JOORNAL KOJNIKH E VENERICHESKIKH BOLEZNEI.

(Jan., Feb., Mar., 1915, xxix, Nos. 1 to 3.

Abstracted by M. L. Ravitch, M.D.

MULTIPLE IDIOPATHIC HÆMORRHAGIC SARCOMA OF THE SKIN (KAPOSI). Groigoryev, p. 3.

Kaposi, in 1872, classified this disease as a separate nosological entity, describing it as brown, bluish or purple spots on the feet, hands and face, due to hæmorrhages in the skin; these spots afterward develop into flat or raised nodules, varying in size from a shot to a cherry; this is usually preceded by œdema and pruritis. In a later stage these nodules may enlarge or swell as if fluid were accumulated in them; they are painless, as a rule, though Schwimmer reported some very painful ones. Besides these nodules or tumors, a diffused elephantiasis was observed in some cases, as has been described by Pick, or infiltrations alone may appear, as in Kracht's case.

There are many deviations from the description of Kaposi. For example, Prof. Tanturri, in 1887, observed in one case (out of his seven cases) that nodules appeared in the region of the knee and also below the ribs. Dr. Fokin exhibited, in 1897, before the 12th International Congress in Moscow, a case of sarcoma Kaposi in which only the clavicular region and palm of the left hand were affected.

The mucous membranes are also sometimes affected; Radaeli, Halle, Kaposi and Seziak mention such cases. In 1869, Kaposi reported that he observed manifestations of the disease in the internal organs at autopsy, in several of his cases, and De-Amicis, Hallopeau, Semenov, Pini, Mariani, Sternberg and others claim that the disease is not uncommon in the internal organs. Scholtz, Bernhardt, Halle and Zumbusch found that the caseous structures were sometimes involved. While the majority of the observers deny involvement of the lymphatic glands, Tanturri, Deballa, Schwimmer and Sellei claim to have observed cases in which some lymphatic glands were affected. Satrapa, Semenev, and Tiptzer believe that the appearance of headaches, neuralgia and paræsthesia and an increase in the reflexes show that the disease affects the nervous system. It is peculiar that women rarely suffer from this disease, according to many observers. As to blood changes in multiple hæmorrhagic sarcoma (Kaposi), the majority of the observers could find nothing of significance. In the later stages of the disease, after cachexia has set in, there is the expected decrease in hæmoglobin and low number of erythrocytes, and also an increase

in the leucocytes. Urinalysis does not show any change in the urine in this disease.

The ætiology of the disease is rather obscure, and those who have observed cases of it, advance different theories. The infectious theory has as many adherents as does that which attributes the disease to systemic disturbances.

Geographic distribution does play an important part. Statistics show that the disease is more prevalent in Poland, Austria-Hungary and Italy, but a racial susceptibility to this disease has not been established.

The results of treatment have been very unsatisfactory, though X-ray and Finsen light treatment have proved very beneficial in some cases.

The author cites several interesting cases and gives the minute anatomy of his pathological findings; the latter, however, are no more definite than those described by Fordyce, Wende and others.

THE TREATMENT OF BURNS. Beck, p. 27.

Bogrov describes Beck's treatment of burns in the children's clinic in Budapest. After all of the blisters have been opened, the patient is immersed in a bath, for 5 to 30 minutes, at a temperature of about 90° F. Afterwards the burns are covered with warm bandages soaked in a solution of 1-4,000 of potassium permanganate, the bandages being changed every half hour. If possible, a bath of very mild potassium permanganate solutions are given for 30 to 40 minutes twice a day. To maintain the heart action, hypodermic injections of digitalis or camphorated oil are administered. The children are fed milk in small portions. Later, ointments of 8% of amido-azo-toluol and 5% bromide of zinc are applied for the purpose of hastening epithelial proliferation, and prolonged baths without permanganate of potassium are given. Every fourth or fifth day borated vaseline is applied to prevent irritation of the skin. Excessive granulation is checked by the silver nitrate stick. Massage is advised when cicatrization sets in. In case of keloid formation, carbon dioxide snow is advocated; sometimes injections of fibrolysin are of benefit.

THREE INTERESTING CASES OF PARAKERATOSIS AND ITS PHYSICOTHERAPY. Maki, p. 35.

Mescherski cites Maki's three interesting cases of parakeratosis. Two of those cases were in two brothers; the other in a girl, 18 years old. Different methods of treatment were used, and, as a result, it was decided that applications of carbon dioxide snow were the most effective. The author claims that the X-ray, light from a quartz lamp, and radium and mesothorium radiations were also found of considerable value.

TREATMENT OF SYPHILIS BY INJECTIONS OF STRONG SOLUTIONS OF BICHLORIDE OF MERCURY. Kakushkin, p. 53.

The treatment of syphilis with injections of strong mercury bichloride solutions was introduced by Oeatreicher in 1889; he used 4, 6, 8 and 10% solutions. In 1892, Ludaziewicz used $HgCl_2$ solutions, starting the patient with 1 cc. of a 3% solution, increased later to 1 cc. of a 5% solution. He believed that the slight reaction and absence of intoxication and bad secondary effects spoke in favor of these injections. Miller, in Lassar's clinic, used an 8% solution, injecting only ½ cc. Pellagati, Piasacki, Immerwohl and Malberle used it with success, but Jessner met with very bad reactions. Zelenev preferred mercury suspended in liquid petrolatum. Prochorov injected very large doses of

mercury biniodide in what he called his dynamic method; *i.e.*, he measured his doses according to the weight of the patient: 1 cc. of a 10% solution to each 10 kilo weight of the patient. However, he had severe reactions. Nario and Burdjalov employed the same method.

The 47 cases treated by the author were divided into 3 groups; one group was treated with injections of strong bichloride of mercury solutions, one by mercury and arsenic, and one by arsenic alone. The author comes to the conclusion that injections of strong bichloride of mercury solution have no advantage over other methods of treatment.

BRITISH JOURNAL OF DERMATOLOGY.

Jan. to Mar., 1916, xxviii, Nos. 1 to 3.

Abstracted by I. Rosen, M.D.

SECONDARY LICHENOID TRICHOPHYTIDES IN ASSOCIATION WITH KERION CELSI (LICHEN SPINULOSUS TRICHOPHYTICUS).

C. Rasch, p. 9.

(Translated from the Danish by W. Jenkins Oliver.)

Rasch reports two cases, one a boy, thirteen years of age, and the other a girl, twelve years old; both of them were admitted to the University's Dermatological Clinic at the Rigshospital in Copenhagen, with a large kerion of the scalp. About seven to eight weeks after the appearance of the lesion on the scalp, an eruption consisting of densely placed miliary papules, occurring chiefly in groups, made its appearance on the chest, arms and legs. The papules were white, pink, or the color of the skin, very hard and almost "horny" to the touch. On many of them was a small bristle or spine, a few millimeters in length, which could be removed by traction, leaving a small cavity in the skin. Microscopical examination failed to reveal any fungus.

The kerion, treated with fomentations, healed in about six weeks, but the lesions on the body continued to spread, so that the whole trunk was eventually covered by the eruption.

The author considers these two cases typical examples of "lichenoid trichophytide," first described by Jadassohn, in 1911, during the discussion on Bloch's discourse on ringworm, at the Swiss Medical Congress, in October, 1911. Jadassohn at that time made the following remarks: "With kerion celsi, especially about the time of healing, he had often seen, either in groups or diffusely spread, an eruption which consisted of small pale follicular nodules, sometimes very numerous, at other times in lesser numbers, which after some time disappeared. They most closely resembled lichen scrofulosorum, but did not react to tuberculin injections and were also histologically different from this disease. Occasionally they showed small horny spikes or spines, and the condition might then be said to correspond to the picture of lichen spinulosus."

Histologically, there is a follicular or perifollicular inflammatory condition. The follicle is more or less dilated, being filled with a mixture of round and epithelial cells. In the spinous form there is considerable parakeratosis in the wall of the follicle, and the horny layers in connection with it are pushed out of the follicle by the pressure inside, so giving rise to the development of a bristle or spine.

The condition with which it may most readily be confounded is lichen scrofulosorum. This can be ruled out by the history of the case, the lesions being more grouped and of a darker color, and the distribution is more limited.

With regard to the differential diagnosis from lichen spinulosus, the author is of the opinion that some of the cases previously described under this name are probably identical with the "lichen trichophytides."

TWO CASES OF HERPES ZOSTER ASSOCIATED WITH A GENERALIZED ERUPTION OF VARICELLA-LIKE SPOTS: ONE OF THE CASES FOLLOWED BY OCULO-MOTOR PARESIS, MYDRIASIS AND FRONTAL ANÆSTHESIA. F. Parkes Weber, p. 13.

Weber reports two cases, one a man, 59 years of age, who was suffering from chronic lymphatic leukæmia, with considerable enlargement of the cervical, axillary and inguinal lymphatic glands, and enlargement of the spleen and liver. The glandular enlargement began about six years ago.

The patient received arsacetin (dose not given) on Nov. 6, 1915, and two weeks later, an eruption typical of herpes zoster made its appearance on the right shoulder; this was accompanied with a great deal of pain. About five days later a generalized but scanty eruption of varicella-like spots occurred.

The second patient was a widow, 60 years of age, who during the latter part of August and beginning of September, suffered from an attack of neuralgia of the left side of the head in the occipital region, and in the area of distribution of the first branch of the fifth cranial nerve. About the middle of September, an eruption of typical herpes zoster appeared on the forehead, covering practically the entire left side, involving the left upper eyelid, and left side of the nose. Considerable œdema accompanied this eruption. About the end of the week following this eruption, a generalized varicella-like eruption appeared, covering the entire trunk and extremities.

About six weeks after the appearance of the herpes zoster, the patient complained of diplopia, and this on examination was found to be due to paresis of the left rectus superior muscle. The eyeball was considerably injected throughout the illness, lachrymation was marked, and a muco-purulent discharge from the conjunctiva existed.

Improvement was very slow, and not until four and a half months from the beginning of the illness was the patient considered cured.

SPECIFIC HYPERSENSITIVENESS, OR ALLERGY IN RELATION TO CERTAIN ERUPTIONS OF MICROBIC ORIGIN. H. G. Adamson, p. 27.

The view that tuberculides are virtually "phenomena of Koch" induced by autoinoculation by virile tubercle bacilli, in a subject hypersensitized by previous infection, is one of great interest. The same idea may be applied to the secondary eruptions of syphilis and possibly to certain other skin affections of microbic origin.

"Tuberculides," in contrast to the other tuberculous affections of the skin, show no tendency to local spread, as, for instance, the lesions of lupus vulgaris, and they eventually arrive at a spontaneous cure. This has been explained by the theory that tuberculides are due to tuberculo-toxines, or perhaps to dead or attenuated bacilli, which have not the power to multiply locally, and thus to cause persistent or spreading lesions.

In support of his theory, intradermic injections of tuberculin or bacillary emulsion, in tuberculous subjects, produces lesions of erythema induratum and

lichen scrofulosorum. These eruptions can occur only in persons who have been previously infected by the tubercle bacillus, and whose system is consequently hypersensitive.

In syphilis, the chancre represents the local result of the initial infection. By this infection the subject becomes hypersensitized or allergic towards the micro-organisms of syphilis, and thus protected from a second infection. The secondary eruptions may be looked upon as "cuti-reactions" or as "phenomena of Koch," a result of the arrival of spirochætæ in the skin of the now highly allergic subject.

The tuberculides and the secondary syphilides are not the only eruptions whose characters of symmetrical generalized distribution, and of advance towards spontaneous cure, may be accounted for upon the hypothesis of Koch phenomena in allergic subjects, for we find the same phenomena in the eruptions of measles, enteric fever, varicella and smallpox.

FOUR CASES OF SCLERODERMIA ASSOCIATED WITH DISEASE OF THE THYROID GLAND. J. H. Sequeira, p. 31.

Sequeira reports in detail four cases of sclerodermia (all of them in females), associated with disease of the thyroid gland.

In discussing the pathogenesis of sclerodermia, the author states that this affection occurs in connection with such a variety of conditions that it is difficult to believe that many of the casual relationships which have been suggested can be accepted.

While it is true that a certain proportion of the cases are associated with affections of the thyroid gland, nevertheless there is nothing to warrant the conclusion that alterations in the activity of the gland or of its secretion are actually causative of sclerodermia. The very fact that sclerodermia has been known to occur in thyroid hypertrophy and thyroid atrophy, makes one cautious, and in the author's fourth case, in which the sclerodermia developed in a myxœdematous patient under thyroid treatment, seems sufficient to cast doubt upon the view that sclerodermia develops as a result of deficient or excessive thyroid secretion.

JOURNAL OF EXPERIMENTAL MEDICINE.

(January, 1916, xxiii, No. 1.)

Abstracted by R. C. Jamieson, M.D.

A PATHOLOGICAL STUDY OF SYPHILITIC AORTITIS AND ITS SEROLOGY. J. H. Larkin and I. J. Levy, p. 25.

The authors found that the luetic aortitis in the gross specimen presented a typical picture, the lesion being usually in the ascending and transverse parts. There is a diffuse dilatation, or an aneurysmal pouch, and the surface shows a number of elevated, white scars. There is a perivascular round cell infiltration of the adventitia. The early cases show the histological changes, the gross changes not being so apparent. They consider an aortic insufficiency, uncomplicated by other lesions, to be always luetic except in cases of infectious endocarditis, and think that it is doubtful if the spirochætæ pallidæ can be demonstrated.

In the serology they prefer to use the guinea-pig heart antigen and explain the discrepancy in the Wassermann reaction findings in heart cases, by the fact that the different types of lesions are not sufficiently differentiated by clinicians, pure aortic insufficiency giving approximately 100% positives. With few exceptions, the Wassermann reaction remained positive after treatment.

(*Ibidem*, March, 1916, xxiii, No. 3.)

STUDIES ON TREPONEMA PALLIDUM AND SYPHILIS. II. SPIROCHÆTICIDAL ANTIBODIES AGAINST TREPONEMA PALLIDUM. M. McBURNEY, p. 329.

Using cultural spirochætæ pallidæ the authors found that rabbits and sheep, immunized with these cultures, possessed a serum having spirochæticidal properties, the normal serum, however, also possessing a certain degree of such action, the result of the immunization evidently being to increase the normal antibodies. The spirochæticidal properties are destroyed at 56° C. The addition of small amounts of fresh normal serum will reactivate this action of the immune serum.

III. THE INDIVIDUAL FLUCTUATION IN VIRULENCE AND COMPARATIVE VIRULENCE OF TREPONEMA PALLIDUM STRAINS PASSED THROUGH RABBITS. H. ZINSSER, J. G. HOPKINS, AND M. McBURNEY, p. 329.

Fourteen strains were used passing through inoculations from two to twenty-one generations. They found no constant change in the virulence of the different strains by passing through successive rabbits, nor did the different strains vary, though the original material had been obtained from various types of lesions—condylomata, chancres, mucous patches and the nervous system.

The speed of incubation was, with slight differences, the same for all strains, the nature of the lesion resulting from inoculation of any individual strain depending upon the material used, the technique employed for injection and the size of rabbit used. The testicular development of the rabbits used accounted for some of the variation in the results obtained.

IV. THE DIFFERENCES IN BEHAVIOLC 1 IMMUNE SERUM BETWEER CULTIVATED NON-VIRULENT TREPONEMA PALLIDUM AND VIRULENT TREPONEMA PALLIDUM FROM LESIONS. H. ZINSSER, J. G. HOPKINS, AND M. McBURNEY.

It was found that antibodies could be produced in the process of immunizing animals to *cultivated* treponema pallidum, which antibodies had agglutinative and spirochæticidal powers upon the cultivated organisms. It was also discovered that these antibodies possessed no action upon the virulent organisms obtained directly from the lesions. The article gives a detailed report of the experiments to determine agglutination and treponemicidal action.

ANNALES DE L'INSTITUT PASTEUR.

(January, 1916, xxx, No. 1.)
Abstracted by R. C. Jamieson, M.D.

CERTAIN ALTERATIONS IN BIOLOGICAL PROPERTIES OF SPIROCHÆTÆ THROUGH ARTIFICIAL CULTIVATION. Hideyo Noguchi, p. 1.

Experimental work has proved that an odor-producing treponema is not the organism of syphilis. The different varieties of treponema obtained in pure culture are the pallidum, pertenue, macrodentium, microdentium, mucosum, calligyrum and refringens. The staining properties and morphology of these varieties in culture have remained practically unchanged during several years, but the virulence of the pallidum was lost after about four months; the microdentium became almost odorless in two years; the mucosum also lost its mucin-producing properties.

AMERICAN JOURNAL OF THE MEDICAL SCIENCES.

(March, 1916, cli, No. 3.)
Abstracted by R. C. Jamieson, M.D.

SYPHILITIC BURSITIS, WITH REPORT OF A CASE. R. W. Scott, p. 386.

This article is a report of a case in which the prepatellar bursæ on both sides were involved in a gummatous process. Pathological examination showed a gumma, and the Wassermann was positive.

This case can be added to those few already reported.

ARSENOBENZOL.

Resolution by the Council of the American Dermatological Association.

Whereas, the importation of Salvarsan has been stopped by the war in Europe and the loss of this valuable remedy would have entailed serious consequences to the life and health of the afflicted, and indirectly to the health of the community; and,

Whereas, Drs. Schamberg, Raiziss and Kolmer, after an extended research, have produced in Arsenobenzol a substance equivalent to, if not identical with, Salvarsan and have placed it at the disposal of the profession;

Now, Therefore, Be It Resolved, that this Association record its appreciation of the valuable service rendered to the profession and to humanity through the successful efforts of these gentlemen.

SALVARSAN.

For the benefit of our readers we announce (see advertising pages) that a large supply of salvarsan has been received in this country from Germany. Dr. Schamberg, who has done so much to offset the harm occasioned by the absence of salvarsan, will not supply more arsenobenzol unless the supply of the German product again fails.

NEWS ITEMS.

Dermatological Appointments to the German Hospital:

Dr. Sigmund Pollitzer has been appointed Honorary Physician;
Dr. Howard Fox, Visiting Dermatologist, and
Dr. H. R. A. Graeser, Assistant Visiting Dermatologist. H. F.

Hay Fever Vaccine Mulford

For the Prevention and Treatment of

Hay Fever, "Fall" or "Autumnal" Type

Hay Fever Vaccine "Fall". Mulford contains the protein extract from the pollens of ragweed, golden rod and maize, dissolved in physiological saline solution and accurately standardized, and may be used without preliminary diagnostic tests. If treatment does not give entire relief, skin tests may be made to discover possible hypersusceptibility to pollen not contained in the Vaccine.

Noon, working in Sir Almroth Wright's Laboratory, was the first to report successful results in the treatment or prevention of hay fever with subcutaneous injections of pollen extracts. Clowes, Lovell, Lowdermilk, Ulrich, Hitchens and Brown, Koessler, Manning, Cooke, Wood, Goodale, and many other scientists have amply confirmed Noon's work.

Hay Fever Vaccine "Fall" is furnished in:

Packages containing 4 sterile glass syringes
of graduated strengths, $5.00
In single syringes "D" strength, 1.50

Syringe	A	contains	0.0025	mg.	extract	of	the	pollen protein
"	B	"	0.005	"	"	"	"	"
"	C	"	0.01	"	"	"	"	"
"	D	"	0.02	"	"	"	"	"

In ordering Vaccine for Hay Fever occurring during the late summer specify "Hay Fever Vaccine 'Fall' Type Mulford."

For Immunization against Hay Fever, first dose (Syringe A) should be given at least 30 days before expected attack, followed by B, C and D at five-day intervals. Syringe D strength Vaccine should be used at weekly intervals during the entire period of accustomed attack or until immunity is established.

For Treatment of Hay Fever, the doses are given at five-day intervals, beginning with Syringe A, followed by B, C and D in order, followed with Syringe D at weekly intervals during the entire period of accustomed attack, or until immunity is established.

There are no contraindications to the therapeutic or prophylactic use of Hay Fever Vaccine Mulford so far as known. A small percentage of patients may be hypersensitive to the protein extracts, in which case the doses may be accordingly reduced.

Literature mailed upon request.

MULFORD — FOR THE CONSERVATION OF LIFE — LABORATORIES

H. K. Mulford Company

Manufacturing and Biological Chemists

Home Office and Laboratories

PHILADELPHIA, U. S. A.

MULFORD — FOR THE CONSERVATION OF LIFE — LABORATORIES

JUST PUBLISHED

SECOND PRINTING OF THE SECOND EDITION

OF

A SYNOPSIS OF MEDICAL TREATMENT

BY GEORGE C. SHATTUCK, M.D.

Assistant Physician to the Massachusetts General Hospital

PRICE, ONE DOLLAR AND A QUARTER

THIS work represents an attempt to offer clearly and concisely sound principles of treatment based on known pathology. The methods described are selected from those that have been tried at the Massachusetts General Hospital or in private practice. In succeeding editions and printings this book has become well known to physicians, teachers, and students, and, as stated by the Professor of Clinical Medicine in one of our largest Universities, "Has filled a long-felt need."

On reviewing the Second Edition the *Medical Record* stated:

"The virtue of this book is its brevity. . . It will prove useful to the general practitioner who would review his knowledge of the elements of therapeutics in the light of recent developments. Of particular value is the opportunity which this little handbook affords of gaining an insight into the important rules of treatment as carried out in one of the largest and oldest hospitals of this country. The worth of this book is out of all proportion to its size."

Chapter V (Pages 137-185) is devoted to "Drugs"—Their Action, Elimination, Toxic Effects, Indications, Contraindications, Administration and Dose.

The first four drugs of this list are: SALVARSAN, NEOSALVARSAN, HYDRARGYRUM, POTASSII IODIDUM.

W. M. LEONARD, Publisher - Boston, Massachusetts

"Light as thistledown—Sticks like a leech"

Insoluble in water, mucus, pus, blood, etc. Clings to skin or mucous membrane. Impalpable, non-irritant, soothing, odorless.

THEREFORE

COMPOUND STEARATE OF ZINC

McK&R

FOR

Application or dressing for skin or venereal lesions, excipient for calomel, etc.

DUSTING POWDER

INSUFFLATING

DRY OINTMENT

"Smooth as butter — Clean as snow"

Anhydrous, neutral, odorless, colorless, melts easily, cannot become rancid; protective, emollient,

SOLID ALBOLENE

McK&R

FOR

Local application as a protective or healing agent or as an ointment base to carry medication.

McKESSON & ROBBINS

ESTABLISHED 1833

SAMPLES NEW YORK *LITERATURE*

PRESS OF JAMAICA PRINTING COMPANY, BOSTON, MASS.